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ABSTRACT

This staff development module is part of one of three groups of career guidance modules developed, field-tested, and revised by a six-state consortium coordinated by the American Institutes for Research. This module is designed for guidance personnel who work in counseling and guidance with students in school settings, grades K-12. The goal of this module is to help users become aware of attitudes toward the physically disabled, perspectives held by the physically disabled about themselves, and ways to improve skills associated with open and comfortable communication about disability. The module format consists of an overview, goals, objectives, outline, time schedule, glossary, readings, skill development activities, and bibliography. A Coordinator's Guide is also included with detailed instructions for presenting the module in a workshop setting as well as the facilitator's roles and functions, and the criteria used in assessing the participants' achievement of module objectives. (Author/HLM)

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ENHANCING UNDERSTANDING OF STUDENTS WITH PHYSICAL DISABILITIES

MODULE 17

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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COORDINATOR'S GUIDE

INTRODUCTION

This module is intended to help you learn more about those with physical disabilities so that you may more effectively fulfill your guidance functions for such students. Students with physical disabilities include all those defined as handicapped by Public Law 94-142, the Education for All Handicapped Children Act of 1975, except students who are mentally retarded, learning disabled, or emotionally disturbed. Because of space and time limitations, this module focuses on "individuals who are deaf, hard of hearing,...speech impaired, [or] other health impaired,...and who because of those impairments, require special education and related services."

The workshop is planned to occupy one day, utilizing a number of learning experiences: films, small and large group discussion, reading, lectures, and role-plays. The *Workshop Activities and Duration* outlines the day's schedule, and the *Module Goals and Objectives* describe the content of the material.

By the term "physical disabilities" we mean a variety of conditions including limitations caused by disease, injury or accident, or genetic inheritance. Brief descriptions of these conditions are found in the *Glossary*. It's a good idea to look this over during the introductory period so you are familiar with the particular conditions referred to in the text portion of this module.

The module coordinator will introduce the module, explain activities, help you keep on schedule, and otherwise facilitate the workshop. However, many activities depend on your ideas and contributions for success. We hope you will bring your imagination and enthusiasm with you throughout the day so thay you and the other participants will learn as much as possible on a vitally important topic.

MODULE GOAL AND OBJECTIVES

Module Goal

This module is designed for use by guidance personnel in school settings, grades K-12, or participants in pre-service training programs. Such personnel may include professional, paraprofessional and support staff, or anyone else who is part of the team providing guidance services to students with physical disabilities

The goals of this module are:

1. to help participants become aware of widespread attitudes and behaviors toward people with physical disabilities, including the attitudes and behaviors of society as a whole, those which may occur in guidance situations in particular, and those which may exist within themselves;

2. to help participants become aware of the perspectives held by people with physical disabilities regarding the physical and social environments in which they live; and

3. to help participants practice and improve skills associated with open and comfortable communication about disability.

*Module Objectives**

Upon successful completion of this module, you will be able to:

1. Classify example statements by guidance personnel according to three negative assumptions which may exist in their attitudes toward students with physical disabilities and write alternative statements which do not reflect such assumptions.

2. Identify your own attitudes toward people with physical disabilities, in hypothetical situations and in situations from your own experience.

3. List the basic stages of psychological adjustment to physical disability; classify examples of student behavior according to the appropriate stage; and describe a response a guidance staff member could make.

4. A) List physical obstacles faced by students with physical disabilities.

   B) Identify two guidance approaches to help alleviate social problems students with physical disabilities might encounter.

5. Demonstrate behaviors related to open and comfortable communication about physical disability.

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* Assessment criteria for these objectives can be found in the Coordinator's Guide at the end of this module.

WORKSHOP ACTIVITIES AND DURATION

Cumulative duration		
	15'	Introduction
	10'	Film
25'	25'	
		Objective 1
	15'	Text or lecture
	30'	Discussion
	20'	Evaluation
1 30'	1 05'	
		Objective 2
	5'	Text or lecture
	10'	Slides/self-evaluation
	15'	Discussion
2 00'	30'	
		Objective 3
	15'	Text
	20'	Discussion
	15'	Evaluation
2 50'	50'	
		Objective 4
	5'	Text
	45'	Presentation/discussion
	1 20'	Evaluation
4 00'	1 10'	
		Objective 5
	10'	Text
	20'	Model role-play/discussion
	1 00'	Role-plays/evaluation
5 30'	1 30'	
5 45'	15'	Wrapup

PERCEPTIONS, ASSUMPTIONS, AND VARIOUS ASPECTS OF PHYSICAL DISABILITY

Perceptions of Physical Disability

"Skiing? Blind people skiing? Amputees? Why, that's out of the question!"

Generalizations

Preconceptions, assumptions, categories shape our thinking in every area of our lives. Indeed, they are probably essential to our acquiring patterns of everyday behavior which let us function smoothly in our busy lives. Yet because they are generalizations, they are not always accurate when applied to specific individuals. This statement is especially true in this era of society, when everything is changing at an ever-increasing rate--benefits as well as disadvantages.

Assumptions and attitudes about people with physical disabilities are some of the most deeply rooted that exist in our society. Perhaps this is because many of us have very little experience with people with disabilities. Until very recently, families, schools, and the rest of society kept such persons apart from the "normal" world, in special classes, sheltered workshops, and so on. Acknowledgement of those with disabilities as ordinary human beings, co-workers, friends, is not widespread. This distance allows our imagination to "fill in the blanks" as it will; and we usually fill them in with images of sadness and lack: "cripple," "helpless," "hopeless," "limited," "tragic."

Not all societies have treated their disabled members as unfortunates. In *The Disabled and Their Parents: A Counseling Challenge*, Leo Buscaglia notes attitudes toward physical exceptionality in other times and places:

> The Masai Indians murdered their disabled children; the Azand tribe loved and protected theirs.
>
> The Chagga of East Africa used their disabled to ward off evil; the Jukun of the Sudan felt that they were the work of evil spirits and abandoned them to die.
>
> The Sem Ang of Malaysia used their crippled as wise men to settle tribal disputes; the Balanese made them

a societal 'taboo.'
The ancient Hebrew saw illness and physical defects as a mark of the sinner; the Nordics made them Gods.[1]

No doubt our society will never treat its disabled as gods, though we do sometimes react to a physical impairment as if its possessor were a devil. The ideal situation is one in which those with disabilities are seen as they are: whole people, with strengths and limitations like everyone else.

The Ideal Situation

Assumptions About People with Physical Disabilities

It is usually not difficult for guidance personnel to identify the *facts* about their clients with disabilities. Doctors, parents, psychologists, and teachers can describe medical and behavioral limitations or problems. Literature and resource agencies can offer information on prosthetic devices, life-management aids, and other practical needs. But in order for the guidance staff to play a positive role in the client's life, their *attitudes* must be free of those limiting, negative, fearful preconceptions about disability we have mentioned. Basically, people in the guidance profession must be sure they have thoroughly examined their own attitudes, and are maintaining their commitment to the basic guidance challenge: to see the person first, and the problem second. In other words, they must be able to view their clients as "persons with physical disabilities" instead of "physically disabled persons."

Attitudes of Guidance Personnel

Putting this basic commitment into practice in the guidance relationship may require some searching into one's blind spots. Often negative assumptions are unconscious; the "usual" way of behaving towards the person with a particular disability seems logical and justifiable in the situation. But the important thing about dealing with

Negative Assumptions

[1] Reprinted from Buscaglia, Leo. *The disabled and their parents: A counseling challenge.* Thorofare, New Jersey: Charles B. Slack, Inc., 1975, p. 171. Reprinted by permission.

physically exceptional people is to realize how widely they *differ* in their functioning--even more than the physically normal--simply because they *are* exceptional. They do not fit many norms in behavior, intelligence, emotional adjustment or physical adaptability.

Significant Facts

In order to surmount limiting attitudes and preconceptions, we need to take a realistic look at certain facts about physically disabling conditions. The variety of types and extent of disablement brings a few facts immediately into view:

1. There is a great variation in functional limitation among those classified as possessing a particular type of disability.

2. Technological change has created vast new possibilities for compensating for physical limitations.

3. The individual's attitude and will to accomplish can bring about achievement that may seem impossible with a given disability.

Variation in Limitations

When we think of physical disability, it is usually in terms of the "rare exception." But the fact is that over half of us have some kind of physical defect that causes a functional limitation: visual problems, speech difficulties, health problems, etc. Milder defects do not usually acquire the label (or the stigma) of "disability," though the difference is primarily one of degree. When we speak of disability, we usually mean moderate to severe disability.

Excellent texts are available describing, in simple medical language, the types, causes, and terminology of various disabling conditions. A selected, annotated reference list and a glossary of common terms and disabling conditions are included in this module for your use. For our purposes it is sufficient to examine the range of limitations which can occur under the same label.

Visual Defects

Vision. Experts estimate that one out of every four

children of school age (25%) has some visual defect. One out of every 1,000 (.1%) has a problem serious enough to be classified as partial sight or blindness; but, as Samuel Kirk states in *Educating Exceptional Children*, "For educational purposes a blind person is one whose vision is so defective that he cannot be educated through visual methods only.... Some children who are legally blind may read large type and function as partially sighted. Some have motion, light, or object perception...."[2] Visual defects may consist of focusing problems of several types, tunnel vision, shape or color discrimination problems, or perceptual dysfunction (as in dyslexia), and may limit reading but not locomotion, artwork but not writing, or many other combinations of abilities.

Hearing Loss

Hearing. Five percent of the school age population is estimated to have hearing loss, but less than one-tenth of this group is usually even identified. Beatrice Wright states, "...it has been shown that two individuals with the same degree and patterning of auditory acuity as measured by pure tone threshhold may differ markedly in auditory functioning as measured by speech-hearing tests...."[3] Hearing loss may be at selective frequencies (conversational frequencies are usually the most audible), selective sounds, or for certain timbres; the child may hear some music but not speech, speech with some visual cues but not traffic sounds, or other combinations. Often children with slight hearing loss are mistakenly classified as dull, stubborn, or retarded.

Speech Defects

Speech. Children with speech defects form the largest number of those with physical disabilities, with estimates ranging from 2 to 20% of the entire school-age population (depending in part on the definition of "defect"). These

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[2]Reprinted from Kirk, Samuel A. *Educating exceptional children.* Boston: Houghton-Mifflin, Co., 1962, 1972, p. 214. Reprinted by permission.

[3]Reprinted from Wright, Beatrice A. *Physical disability: A psychological approach.* New York: Harper & Row, 1960, p. 11. Reprinted by permission.

may range from problems with articulating a few particular sounds, to mild or severe stuttering, to aphasia (inability to understand or reproduce language patterns), and may or may not be related to other problems, such as retardation or cerebral palsy.

Cerebral Palsy

Cerebral Palsy. Many conditions, both physical and behavioral, are connected with cerebral dysfunction, and research continues into many aspects of the topic. The most widely known results of brain dysfunction are the types of disabilities resulting from cerebral palsy. Estimates of the prevalence of cerebral palsy vary from .09 percent to .3 percent. The condition may involve only one limb, or two, three, or all four, and may or may not affect speech, unaided locomotion, and intelligence. One eight-year-old boy, a severely involved* quadriplegic (all four limbs affected) with no speech ability, was considered to be mentally retarded as well, until his parents noticed that he seemed to smile at appropriate places in TV comedies. Special educators developed a system of simple yes-no communication with the boy and were evetually able to test his IQ, which was rated near 140!

Other Conditions

Other disabling conditions. Conditions other than those described above affect a small percentage of children. These may range from temporary situations, such as fractures, to severe and perhaps fatal diseases, such as multiple sclerosis. The glossary in this module briefly describes many such conditions. The variation in limitation imposed by any type of condition is at least as broad as the variation in types of conditions, and no descriptions can be attempted here.

*The term "involvement" refers to the level of disablement caused by a particular condition. Generally it refers to the *degree* of involvement rather than the *extent* (e.g., a paraplegic may be affected in only the lower half of the body, but if that region is greatly impaired, the term "severe involvement" is likely to be used). Degree and extent often are related, however.

Multiple handicaps. Children with more than one disabling condition are usually classified as severely disabled; they form less than 2% of the population of children with physical disabilities. Until recently, these children were rarely seen in regular school programs, but this situation is changing as the concept of mainstreaming grows in recognition. Some multiple disabilities are due to one underlying condition, such as speech and locomotion difficulties caused by cerebral palsy or speech difficulties caused by hearing loss. A physical disability may be paired with a non-physical disability, as in blindness plus mental retardation. Of course, each of the multiple disabilities can vary in the ways we have discussed, either singly or in conjunction with others.

Multiple Disabilities

This situation, however, illustrates again that the *actual* limitations of each person with a disability must be determined by *exploring that person and his/her situation individually*. General information, such as "Diabetics who are involved in strenuous exercising will need to stop and eat at frequent intervals," offers helpful guidelines; but guidance or teaching staff members cannot assume any specific functional limitations in a student with a disability until all possible information is gathered from the student, from family, medical experts, teaching staff, school nurse and/or psychologist, and any others with knowledge of the student.

Determining Functional Limitations

Technological and Functional Aids

Improvements in medical care have turned some disabilities into virtually nonexistent problems. For instance, some diabetics and epileptics can so control their conditions that they are not even apparent in their daily lives, much less an interference with their functioning.

Medical Advances

Even for those whose disabilities are functionally apparent, tremendous strides have been made in only the last few years toward filling their exceptional needs. For the blind, in addition to Braille styluses and typewriters,

Technical Advances

Talking Books, and other common aids, new technology has produced talking hand-held calculators and canes equipped with laser beams which detect obstacles and sound different tones to indicate an obstacle's approximate height. Prosthetic devices of all types are constantly being improved; for example, people with cleft palates can be fitted with plastic devices which nearly close off the palatal opening and make speech training results much more satisfactory. Computer-operated artificial hands and limbs are being developed and improved. Surgical improvements, such as the use of plastic pins instead of traction for setting bones, lessen the duration of recovery from injury and thereby lessen the severity of long-term damage from fractures. Wheelchairs can be equipped with pressure-sensitive, heat-sensitive, or even breath-sensitive motor control mechanisms which allow people with virtually no muscular control to be mobile. And special teletypewriter machines allow deaf people to carry on conversations over regular telephones, with readouts either on paper or on a screen.

Technological development will continue, of course, and its direction will no doubt continue to improve functional aids for those with physical disabilities. The various associations which have been organized for the benefit of people with particular types of disabilities (such as those listed in the Appendix) are among the best sources of knowledge about new developments. Perhaps these technological and medical innovations will also eventually decrease or eliminate the occurrence of many conditions altogether.

Will and Attitude

Attitude

The *most* significant factor in the life of the person with a disability is of course her/his own attitude. This attitude is shaped by many factors as the child grows; the attitudes and behavior of the family and other people close to the child are among the most significant and may affect the child either positively or negatively. Many authors,

both those with physical disabilities and those without, agree with the blind girl in the film that the person's attitude forms the crucial difference between a "disability" and a "handicap." Beatrice Wright, in her book *Physical Disability: A Psychological Approach*, concludes:

> ...a physical attribute is a physical handicap only when it is seen as a significant barrier to the accomplishment of particular goals. This means that, in the individual case, a physical disability may or may not be a physical handicap. This is also true of a physical attribute that is not a deviation. Moreover, a physical attribute may become handicapping not because it is physically limiting, but because it adversely affects social relationships.[4]

Limitations?

This does not mean that "anybody can do anything." Certain physical limitations *do* preclude particular activities, at least as *means* (though the same *ends* may still be achievable). But even severe physical conditions are only "handicapping" in so far as the attitudes of the person with a disability and others in his/her life view them as such. Maria French, a young woman with cerebral palsy involving her entire body, including her speech, writes in Dr. Leo Buscaglia's book *The Disabled and Their Parents: A Counseling Challenge:*

> Part of what I believe is that I am not handicapped in any way. To me, cerebral palsy is not my handicap. The problem does not lie entirely with me, but also with you. The sight of someone who is physically twisted, in a wheelchair, or who has the gait of a drunk, exhibiting contortions and poor balance might elicit in you fears, feelings of inadequacy.... It is sometimes hard to conceive that someone who is really screwed-up physically, with the speech of a drunk, or no speech at all, has <u>the same human needs as you</u>, and perhaps, in some cases, a higher intelligence than yourself. This is where the problem lies, and this is mainly why I agreed to do this chapter for Dr. Buscaglia. I am not doing it to gain pity. <u>Pity is the last thing that I, or individuals like myself need</u>. I am doing it to make you <u>aware</u> that disabilities are but a fraction

[4]Reprinted from Wright, Beatrice A. *Physical disability: A psychological approach*. New York: Harper & Row, 1960, p. 10. Reprinted by permission.

> as disabilitating as attitudes, attitudes that attempt to define, limit and compare. They are what comprise a handicap.[5]

Maria French is earning an M.S. in Rehabilitation Counseling. She also drives a car, camps in the woods with friends, and drinks wine...through a straw!

Assumptions About People with Physical Disabilities

We have made reference to unconscious or unexamined negative assumptions which may limit the effectiveness of guidance personnel. We feel the following statements summarize the most common negative assumptions that may occur in the guidance relationship with a student with a disability.

Negative Assumptions

1. All mental, emotional, and learning problems exhibited by a student with a physical disability are directly related to her/his disability.

2. The same sequence of course work, the same kinds of career plans, and the same limitations on life management and leisure goals and activities are appropriate for all students possessing a similar type and degree of physical disability.

3. Students with physical disabilities, especially those with great involvement, have no needs other than those directly related to their disabilities.

Stated so unconditionally, these assumptions look transparently false. Yet over and over, ineffective guidance relationships reveal incidents of behaviors which fit one of these general statements. It is not always easy to be aware of the operation of these assumptions, since they categorize those with disabilities in ways which are accepted and unchallenged by much of society. Let's look at how they may appear in practice.

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[5] Reprinted from Buscaglia, Leo. *The disabled and their parents: A counseling challenge.* Thorofare, New Jersey: Charles B. Slack, Inc., 1975, p. 235. Reprinted by permission.

Linking ALL Problems to Disability

1. ALL MENTAL, EMOTIONAL, AND LEARNING PROBLEMS EXHIBITED BY A STUDENT WITH A PHYSICAL DISABILITY ARE DIRECTLY RELATED TO HER/HIS DISABILITY.

A 14-year-old boy was losing his sight slowly as a complication from diabetes. He suffered from severe and unremitting depression which the guidance staff attributed to his fear of his growing disablement. He became nearly suicidal before contacts were established by the staff with his parents. It soon became evident that his mother was unable to accept the fact of his coming blindness and was influencing him greatly by her despair. This relationship, and not the blindness itself, was the major cause of the boy's depression. Counseling for both the boy and his mother helped them both to begin the process of adjustment, of looking at the many things he *could* do instead of what he could not.

Other students of all ages may show the results, in either their educational levels or emotional adjustment, of overprotection by their families or cruel rejection by others. These may be difficult problems, but they do not necessarily relate directly to the degree of physical disability at all. Instead they may stem from the attitudes which other people in the person's life have taken or are taking towards that disability. They may even stem from a different, perhaps undetected physical problem.

It is worth noting at this point that the process of counseling persons with disabilities will virtually always mean also counseling with parents and/or others in the home. They are the ones with the deepest concerns for the person and the largest impact upon his/her development. They are also the greatest source of knowledge and insight into their child and the greatest potential power for helping her/him. Their knowledge about their child's problem and their attitudes toward it may be either aiding or hindering the child's development, and it is part of the job of the guidance staff to learn about the whole situation. But in

either case, understanding the parents, learning from their knowledge, and helping them with their problems cannot be left out of a vital, responsive guidance process.

Categorizing Life Activities According to Disabilities

2. THE SAME SEQUENCE OF COURSE WORK, THE SAME KINDS OF CAREER PLANS, AND THE SAME LIMITATIONS ON LIFE MANAGEMENT AND LEISURE GOALS AND ACTIVITIES ARE APPROPRIATE FOR ALL STUDENTS POSSESSING A SIMILAR TYPE AND DEGREE OF PHYSICAL DISABILITY.

This may seem an obviously poor approach to counseling anybody, either with a disability or without. But it is all too common for people with disabilities to be viewed in terms of their limitations *first*, instead of their strengths and desires, and for plans for their futures to be developed on such bases. (Blind students end up in the fields of radio broadcasting and piano tuning much more frequently than the general population.) Often, especially for people with severe disabilities, these limitations create assumptions about their ability to ever assume independent status and productivity in society. A lifetime of dependence on the family or a sheltered workshop may be the only option even considered, by both the family and the guidance staff. Yet growing numbers of people with disabilities are proving that they *can* function independently: setting up their own homes, alone or with others; learning to deal with architectural and other physical barriers; learning to utilize public transit, transportation services, or their own vehicles; and holding down jobs of every sort. A young man in Berkeley, California, whose cerebral palsy confines him to a wheelchair and makes his speech difficult to understand, teaches computer programming at a vocational school. His students have trouble understanding him at first, and he needs help in developing written class materials, but he knows what he's doing and his students soon do, too.

Of course some physical limitations are unchangeable at our current level of expertise, and students must be helped

to acknowledge the facts of their limitations if this has not already happened. But jumping too soon to such conclusions may eliminate the possibility of seeing other ways to the desired goal and confine guidance staff to seeing only the common ways. People in wheelchairs may not be able to walk, but they *are* able to play basketball--as long as no one insists they do it the usual way!

Limiting Needs to Disability

3. STUDENTS WITH PHYSICAL DISABILITIES, ESPECIALLY THOSE WITH GREAT INVOLVEMENT, HAVE NO NEEDS OTHER THAN THOSE DIRECTLY RELATED TO THEIR DISABILITIES.

When we look at a boy in a wheelchair, unable to walk, speak coherently or even hold his hands steady, it is easy for the obvious needs connected with his physical condition to blot out awareness of other needs he might have. Sexual needs are an important example. Since their social relationships may not be comfortable and communicative, many people with physical disabilities may have neither the chance to talk about nor the chance to satisfy their sexual needs, particularly as teenagers. Parents may not have been able to discuss the subject fully or at all, and teachers or other professionals may not have been able to deal with the student's needs for special information and reassurance. One reason for this, on the part of both parents and professionals, may be an aversion (conscious or unconscious) to associating sexuality with physically deformity or defect. But the needs remain, and unless students can be helped to understand and accept their needs and situations in this fundamental area, problems of personal unhappiness and/or unacceptable public behavior are all but assured.

Other common human needs are often overlooked in comparison to evident physical problems. The needs for friendship, for intellectual stimulation, for excelling at something, and for physical exercise are as strong in those with disabilities as in those without. As well as providing or encouraging fulfillment of these needs as much as they can,

guidance staff may also be able to work with parents, teachers, and other students to develop settings in which these needs can be fulfilled. Parents can be encouraged to invite the student's classmates to social or study gatherings; P.E. teachers are often willing to establish special P.E. classes adapted to those with disabilities; students can perhaps be sensitized to the needs and situations of people with disabilities, in existing classes taught by counseling staff or in specially planned groups. And all those who care about the student can be encouraged to be aware of subjects and activities that can fit in with, stimulate, and increase her/his interests and skills.

Identifying Attitudes in Practice

Recognizing Attitudes and Assumptions

The three statements we have presented represent attitudes (usually unconscious) toward those with disabilities. Putting them into words makes it obvious that they represent stereotyped ways of thinking; but identifying them in everyday conversations is not always easy. The activity which follows is designed to help you look at these assumptions in practice.

ACTIVITY #1: EXAMPLE STATEMENTS BY GUIDANCE PERSONNEL

In this activity you will be examining a number of typical statements which guidance personnel might make to colleagues, students, or parents. The coordinator will provide suggestions for discussing the questions under each statement, for the purpose of identifying the assumption underlying each, how the assumption is expressed, and how it could be eliminated. The three assumptions are stated as follows:

1. All mental, emotional, and learning problems exhibited by a student with a physical disability are directly related to her/his disability.

2. The same sequence of course work, the same kinds of career plans, and the same limitations on life management and leisure goals and activities are appropriate for all students possessing a similar type and degree of physical disability.

3. Students with physical disabilities, especially those with great involvement, have no needs other than those directly related to their disabilities.

1. A counselor says to a colleague, "This boy's got problems. He hasn't really got any friends. His self-consciousness about his stuttering must color his whole life."

a. What <u>facts</u> about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What other possible causes could the student's behavior have?

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

2. A guidance staff member says to a teacher, "Maria's muscular dystrophy has finally confined her to bed. I advised her parents not to let her know much about what's going on in school; I think it would just hurt her to hear what she's missing."

a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What other student needs might be present here, unrelated to the disability?

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

3. A counselor says to a student, "I think, Sally, we should choose music courses for your fine arts requirement. I know you can see a little, but I don't think you could succeed in an art course."

a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

e. How could this statement be changed so it states the same facts but does not express any negative assumption?

4. A secretary in the guidance office says to another staff member, "Sherry's sure not a very energetic girl. I guess being blind really limits her confidence in her ability to move--because even a small movement may mean she gets hurt or bumped or she trips or something."

a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What else could cause the student's behavior?

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

5. A guidance staff member says to a teacher, "Cindy came in this morning and said Walt tried to kiss her. She was really upset; his paralysis and his drooling made her sick. How could he even think about touching such a pretty girl!"

a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What other student needs might be present here, unrelated to the disability?

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

6. A career center staff member says to a parent, "I don't see how Pat could become a nurse with her hearing problem. She couldn't hear patients call for help, or use equipment which transmits information by sound. I think we should skip that option as a possible career for her."

a. What <u>facts</u> about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

e. How could this statement be changed so it states the same facts but does not express any negative assumption?

Name _____

EVALUATION #1

Below are three statements of negative assumptions we have been discussing. Following those are two statements which might be made by guidance personnel. You are to answer the questions following each statement. Six of the eight answers must be correct or acceptable for you to achieve this objective.

1. All mental, emotional, and learning problems exhibited by a student with a physical disability are directly related to his/her disability.

2. The same sequence of course work, the same kinds of career plans, and the same limitations on life management and leisure goals and activities are appropriate for all students possessing a similar type and degree of physical disability.

3. Students with physical disabilities, especially those with great involvement, have no needs other than those directly related to their disabilities.

1. A guidance staff person says to a student with a moderate cerebral palsy condition, "Linda, Mrs. Anderson is delighted with your work in geometry. I've got you in an advanced algebra course for next semester. Of course we'll waive the course in cooking and home management; I doubt that you could get around or manage equipment in there very well, and anyway, you won't need it, since you'll no doubt always be living at home."

a. Which assumption above is <u>most</u> closely reflected by this statement?

b. What are the <u>facts</u> expressed in this statement?

c. What part(s) of the statement express(es) the negative assumption? (Underline the words of the statement. Underline whole phrases or sentences.)

d. How could you revise the statement so it reflected the facts, but not the assumption?

2. A guidance staff member says to a guidance intern, "Brian's deaf, can't hear anything at all. He's got emotional problems too--doesn't get along with teachers or other kids very well. No doubt the two situations are related."

a. Which assumption above is <u>most</u> closely reflected by this statement?

b. What are the <u>facts</u> expressed in this statement?

c. What part(s) of the statement express(es) the negative assumption? (Underline the words of the statement. Underline whole phrases or sentences.)

d. How could you revise the statement so it reflects the facts, but not the assumption?

YOUR ATTITUDES TOWARD PHYSICAL DISABILITY

Examining Your Own Attitudes

For guidance personnel encountering more and more students with physical disabilities among their clients, preconceptions and categories have a special impact.

Limiting Preconceptions

1. As the film illustrated, they are usually *limiting*. They create automatic boundary lines in the minds of guidance personnel, beyond which it may never occur to them to look.

Negative Ideas

2. They are usually *negative*. "A blind person cannot attempt this vocation." "The paralyzed polio victim cannot have a sexually fulfilling marriage." "Who would hire a severely involved, unappealing spastic person?"

Unacknowledged Fears

3. They often reflect *unacknowledged fears* on the part of guidance personnel. "I'm just not good at dealing with physical deformity" may mean "I'm afraid I will be contaminated with the same physical defect this person bears, or with the stigma it projects."

In the next activity we would like for you to consider several situations involving you and a person with a disability. Some of these will draw on your own experience and some will be hypothetical. This should help you assess *where you stand now* in your attitudes toward physical disability and its place in your professional life. Perhaps you want to increase your involvement with those with physical disabilities, or perhaps your school situation requires it. Perhaps you feel comfortable at your present level of involvement or in your present attitudes. In either case, we hope you will have a firmer basis for decision after completing this objective.

ACTIVITY #2: SELF-ASSESSMENT AND DISCUSSION

The following questions are designed to help you look at some specific aspects of your experience with people with physical disabilities.

1. If the coordinator is including a slide presentation in this activity, rate yourself on the grid below for each slide shown. Otherwise, go on to question 2.

	I would be very comfortable doing this	I would be willing to do this	I would rather not do this	I would be very uncomfortable doing this
Slide #1 Being introduced to this person for the first time				
Looking straight into this person's eyes while talking				
Touching this person				
Bringing up and discussing this person's disability with him/her				
Slide #2 Being introduced to this person for the first time				
Looking straight into this person's eyes while talking				
Touching this person				
Bringing up and discussing this person's disability with him/her				

If the coordinator is not including a slide presentation in this activity, begin the self-assessment here. Answer each sub-part of each question as accurately as possible.

2. Think of a time you encountered a person with an evident physical defect whom you did not know, in some non-structured setting (e.g., a party, visiting a friend in the hospital, riding on an airplane or train).

a. Were you at all afraid to meet the person's eyes?

____ Yes ____ No ____ I don't know

b. Did you have trouble thinking of anything to talk about?

____ Yes ____ No ____ I don't know

c. Were you afraid you might have to touch the person?

____ Yes ____ No ____ I don't know

3. Think of a time when you encountered a person with some evident physical defect in a co-working relationship.

a. Did you feel apprehensive that discussion might drift away from work-related topics?

____ Yes ____ No ____ I don't know

b. Did you feel embarrassed at any inadvertent reference to the disability, e.g., "For Pete's sake, Bill, look at the figures! Oh--sorry--I forgot you can't...."

____ Yes ____ No ____ I don't know

4. Imagine yourself counseling a 10-year-old blind student. The student shows no facial expression while talking, uses no gestures, her head wobbles, her eyes wander aimlessly, and she does not sit up straight.

a. Do you think you could comfortably bring up the subject of her lacks in communication skills?

____ Yes ____ No ____ I don't know

b. Do you think you could comfortably show her physically, by touching her, having her touch you, etc., what you mean and how she could utilize more of the ordinary communication skills?

____ Yes ____ No ____ I don't know

5. Imagine yourself with a severely involved cerebral palsied boy of 14. His speech is sometimes unintelligible, his arms, legs, and head are pulled into unusual positions, movements are uncontrolled and flailing, and his facial contortions are frequent, including some drooling. His intelligence and achievement levels are in the average range. He requires a wheelchair for movement and, though he feeds himself, it is a messy process for him and the table.

a. Do you think you could comfortably sit through a meal with him and his ungraceful, though effective, manner of eating?

____ Yes ____ No ____ I don't know

b. Do you think you could consider a career future with this boy in which no possibility was ruled out without some consideration?

____ Yes ____ No ____ I don't know

c. Do you think you could conduct a class for physically normal students on the problems of those with disabilities, if you were required to use this boy as an example (verbally, not with the boy present) in discussing "a person with a disability, not a disabled person?"

____ Yes ____ No ____ I don't know

6. Do you remember ever thinking or saying to another person a thought or statement about a student with a disability that reflected any of the negative assumptions in objective 1?

____ Yes ____ No ____ I don't know

7. Was this situation one in which you had enough actual facts to justify your statement, or do you feel, in retrospect, that you were making one of the three negative assumptions we have discussed?

____ I had sufficient facts for my conclusion

____ I was making an assumption which may have been unfounded (or proved to be)

____ I don't know

When all participants have finished, the coordinator will lead a discussion of reactions to physical impairment.

ADJUSTING TO A PHYSICAL DISABILITY

Adjustment to Loss

Like other people, a student with a disability has various needs which require fulfillment for the individual's full development. These needs may be for information, for achievement, or for acceptance by others. Also like other people, some students with disabilities experience difficulty in their emotional development. Often (though not always) such emotional difficulties arise in the process of adjustment to the disability itself and its impact on the student's life. If the self-image is one of physical defectiveness or incompleteness, the student's emotional development faces unusual challenges.

Views of Loss

Various authors have discussed the process of adjustment to disability, as well as the larger topic of loss of the self or important parts or aspects of the self. Among these are Beatrice Wright *(Physical Disability: A Psychological Approach)* and James McDaniel *(Physical Disability and Human Behavior)*. Elizabeth Kübler-Ross examines adjustment to the ultimate loss of self in death *(Death and Dying)*, and proposes a model of the process that is relevant to loss through disability as well. Indeed, several research studies have demonstrated that the severity of illness or incapacity is only one factor influencing the emotional states of people facing functional loss, and in many cases does not correlate directly at all. That is, people with severe impairment may react with *more* positive outlooks than those with milder conditions.

A fourth author in this area is Peter Leech, a clinical social worker and counselor trainer at the Center for Independent Living in Berkeley, California. Some years ago he contracted polio and now requires a wheelchair for mobility. From his own experience and study and that of others, and from the need to help his counselor trainees experience some of the life situations of those with disabilities, he too

has evolved a model of the adjustment process, which is unique in some aspects. Since it is both the most fully developed and the most specific to our topic of all those encountered in the literature, we will examine this model and its implications for counseling efforts in some depth.

Model Limitations

Of course emotional reactions and corresponding behaviors do not conform to simple and precise formulas. This is especially true when one is seeking to sort out client emotions and behaviors which may arise from habitual and long-term repression of certain responses. A theoretical "model" of emotional development must be somewhat artificial, since it vastly oversimplifies and rigidifies a process which may be complicated and distorted by many factors. Nevertheless, separating the process into single elements can be an aid in better understanding the roots of certain behaviors, in choosing more effective responses to behavior, and in deciding how much and what kind of service a client is likely to need from the guidance staff.

A Model of the Adjustment Process

The Community Standard

According to Leech, the fundamental perception of disability is the comparison of the person's actual physical state with the *standard* of his/her community. This standard may differ; for instance, professional football players and professional teachers may have basically different perceptions of the "disability" caused by paralysis of the legs. It is at the moment of perception of this difference from the standard of her/his community that the process of adjustment begins. That is, the congenitally blind child may not understand what "blind" means when s/he is first told about it. The critical psychological moment comes when s/he perceives that "blindness," whatever it may be, makes him/her *different* from the "normal." This realization may occur within the environment of an accepting family, or it may be brought about by the taunts of peers; but at some point, every person with a disability, congenital or newly acquired, will have

to encounter her/his difference from the standard of the society or the social context.

Leech proposes a model of the adjustment process consisting of five fundamental stages:

Five-Stage Adjustment Model

1. Shock
2. Sadness
3. Anger
4. Vulnerability
5. Acknowledgment

This progression of "stages" is not meant to be interpreted as a rigid prescription for any individual reaction pattern. Any kind of reaction may vary in the intensity, the duration of the process, or the direction of moment-to-moment change in feeling--that is, feelings of anger may be followed by the need to express sadness in crying. Indeed, this "interpenetration" of stages is probably the rule, not the exception. But Leech feels that the above model is an accurate description of the general direction of development. It is also a generally accurate picture of the normal sequence of behavior a person with a disability will exhibit after her/his difference from the standard is realized--*IF*, and only if, the person's true feelings are expressed and validated as they naturally occur. We will discuss this conditional statement more fully later.

The Stages and Their Expressions in Behavior

Shock: Inability to Integrate Images

Shock. The first stage, shock, may be manifested both physically and psychologically. The body frequently does not experience anything right after the moment of trauma. Similarly, the mind may simply not be able to comprehend loss or make meaningful the juxtaposition of the image of self and the image of disability. This is not *denial*, in the classic sense of refusal to admit the truth. It is rather an initial temporary stage of *inability* to integrate two previously separate images into a single new image. A state of "unfeeling," a temporary numbness, is the most common

description of this period by people who have experienced disability.

Sadness: Loss of Something Valued

Sadness. The next stage, after perception of the new reality has begun to occur, is sadness at the loss of something valued. This comprehension of the changed self is often not an "all-at-once" experience; the new state seems alternately real and unreal. In the case of disability later in life, the loss is twofold: the body part or function and the image of the self as meeting the standard of society. In the case of those disabled from birth, the latter realization of loss is the main, or only, cause of sadness. The natural expressions of this state are crying and conversation about the lost facility and the pain of loss.

Anger: Several Sources

Anger. The third stage is anger. Anger may have several sources. These may include outrage at the loss of functioning and/or self-image, accompanied by the anguished question, "Why me?"; rejection of the crippled and imperfect self and the newly perceived role it will be asked to play; or both. Frustration over tasks, often even very simple tasks, which cannot be accomplished in the way they once were (or at all) will add to the difficulties of those disabled later in life. Guilt or shame may be evidenced as a reaction to others' opinions, or to what the person imagines others' opinions are. This anger is not necessarily rational or selective about its targets. It may be shown in the form of lashing out at and rejection of the people who would most like to help, especially if there is any possible connection between those people and the fact of disability. "The doctors didn't help enough; my parents didn't try hard enough; my counselor really thinks of me as 'the cripple.'" Anger at God or Fate may be expressed; anger at objects the person cannot effectively manipulate may result in destruction and tantrums; anger at the "handicapped" role which society will impose upon the individual may be directed at anyone, either normal or similarly disabled, deserved or not.

Vulnerability. The fourth stage, a sense of vulnerability, arises from the person's uncertainties about her/his new, or newly perceived, state. Just how limited is the person now, and how much aid will s/he need and be able to get to function in the world? What are the specific attitudes the person may expect to encounter in others? What does the person's future look like in terms of education, social contacts, employment? The person's capacity to meet these new situations is untested, and his/her knowledge of how different or painful they may be is slight; the person may feel and act helpless to control the future or even to visualize it.

Vulnerability: Uncertainty

Acknowledgment. The fifth stage, acknowledgment, includes the person's awareness of *both* the limitations and possibilities of her/his situation. It is the beginning of a realistic approach to meeting actual needs: working within limitations, exploring strengths, and investigating opportunities for new ways of productivity and fulfillment.

Acknowledgment: Awareness of Limitations and Viabilities

These five stages comprise a model of the underlying feeling states of a person who acquires or becomes aware of a difference from the standard. Leech feels these "natural" states are fully described by this model, and that other states, such as denial or depression, are the result of the influence of outside factors. In this he differs from other authors, who describe various behaviors without explicitly defining a causal relationship between them. Leech asserts that if each feeling state can be *perceived* by the person as it actually is, *expressed* straightforwardly to a trusted listener, and most importantly, *validated and supported* by others, denial and depression will not occur. If these states do occur, it means that certain states of feeling were not validated when they occurred. Perhaps the person's own life situations have trained him/her to avoid fully experiencing and identifying such feeling states; or perhaps the feelings were denied by well-meaning or apprehensive family members, friends, or educators.

Typical Behaviors When Feelings Are Repressed

Results of Denying Real Feelings

Many behavior problems that arise are at least partially due to denial of natural feelings; the problems are lessened when such feelings are allowed expression. Someone who is constantly told, "Don't cry," may bottle up and repress sadness over loss; inability to express these feelings will often result in classic denial, and the stage of expression of anger may never be reached. Similarly, depression and apathy are common results of unexpressed or unvalidated anger, perhaps repressed because someone close to the person insists, "Anger won't do any good--don't be angry!" Depression and apathy are different states from sadness, Leech maintains; they are not fundamental feeling states in themselves, but the result of repressing a natural feeling state because it is unacceptable to the individual or to those around her/him. Acting out anger at inappropriate targets or levels is another type of response when natural anger has been previously hidden.

The stage of vulnerability may be mistakenly seen by some as laziness or lack of "guts." Denial of the validity of the vulnerability stage may result from exhortations to "Get on with it!" or similar pressures and may result in unrealistic choices or in fear of making any choice at all. This sort of pressure from others may result from their own anxiety about disabilities and their desire to avoid them. Pressure from others to "accept" a disability may arise from the same source; this is why Leech prefers the term "acknowledgment" for the eventual state of healthy adjustment. Acknowledgment implies a realistic grasp of the situation, including its lacks; acceptance, when imposed as a goal by others, may actually arise from another's desire to avoid the anxiety-producing subject of disability.

Significance of the Model

Importance of Expressing Feelings

This model is important for guidance personnel because it can help them understand the behavior of a student with a disability and use their interpersonal skills most effectively to aid the student's growth. The model suggests (as do many theories of counseling) that *acceptance, support, and validation* of the student's feelings and her/his right to feel them are fundamental. It also suggests that the student may not be fully aware of the feelings underlying his/her own behavior and that the guidance staff may need to explore and direct the student into new levels of thinking and feeling. In some cases it is a unique experience for the student merely to have someone put an accurate label on her/his feeling and discuss it openly. Also, the types of behavior the student displays may offer clues about the extent of help that s/he may need. For example, a student who exhibits a lot of denial or depression is likely to need more or longer assistance than one who displays a great deal of uncertainty.

In addition to helping students understand their feelings, guidance staff may want to assist them to learn new behaviors. An interesting chapter on the subject of behavior change is found in Buscaglia's book, *The Disabled and Their Parents: A Counseling Challenge.*

Some students, of course, have reached the stage of realistic acknowledgment. They may have had open and supportive family environments, previous counseling, or strong personalities before disablement. However, progress toward acknowledgment for those students with disabilities who do exhibit problems may be facilitated by the insights the model offers. Does the student deny limitations and seek the impossible by setting "normal" physical achievement as a standard? Perhaps sadness should be tapped to initiate the helping process. Does the student show anger which seems unwarranted or depression and apathy? Buried anger, or per-

haps both sadness and anger may need to be explored and validated as very natural, reasonable feelings. Does the student hesitate to make choices or engage in activities? The newly disabled or those disabled for a long period may need to work through feelings of vulnerability, uncertainty, and helplessness.

Family Adjustment

A further reason for the significance of the model is that it serves as a reference point for the family's emotional adjustment as well. As we pointed out under Objective 1, much of the student's emotional development is learned from his/her family's modeling and nurturing of emotional patterns, healthy or otherwise. At the birth of a disabled child or the occurrence of disability, the succession of stages of feelings of the family (particularly the parents) often parallels the stages of a disabled person's feelings at recognition of her/his difference from the standard of the community. The parents may not express their feelings in the same terms as their child. The parents' stages of feelings may not coincide with those experienced by the child. Still, if they are recognized and validated (either by trusted others or by the parents' own belief in themselves) it is likely that the parents' feelings of shock and numbness, sadness, anger, uncertainty, and acknowledgment will form an interwoven yet progressive pattern similar to the feelings of the child. If not expressed and validated, those feelings that the parents have repressed are likely to cause parental behavior that may have profound negative effects on the child's development. If parents have not worked through their feelings and acknowledged both the limitations and the strengths of their child, they may pressure the child toward impossible achievement, reject her/him, or become far too protective.

These considerations imply that parents too may need help in dealing with their underlying feelings about their child's disability in order to begin influencing him/her in a more positive way. As we pointed out under Objective 1, a truly helpful counseling effort must always consider the

parents or family. Guidance staff can learn from the family and also assist them with their problems. If family members need help in expressing their natural feelings, the model provides some valuable insights.

Other Kinds of Difficulties

Other Causes of Problems

Problematic emotional responses connected with disabling conditions are not uncommon. However, an important caution in this regard is to avoid *assuming* emotional maladjustment as the root of all problems of those with disabilities and their families. As we said at the beginning of this section, students with disabilities often need what any other student might: information, academic assistance, or help in relating to others. Many of the problems those with disabilities and their families face are very concrete difficulties in obtaining information and services and their resulting frustration and anger may be very appropriate responses. In *The Disabled and Their Parents: A Counseling Challenge*, a mother writes:

> (counselors) must be able to understand that these two people have searched, have wept, have pleaded, have been subjected to embarrassment, have received conflicting opinions about their child and demeaning judgments about themselves.... How often have counselors (or, in the counseling role, teachers or social workers or psychologists or doctors) been heard to say, 'That child's worst problem is his mother--or his father.' How pat and how inaccurate! That mother's and/or father's problem is that kid, and s/he/they have been doing her/his/their utmost to resolve the problem long before landing in that particular counseling situation. Indeed, had their efforts been successful, they would not now be seated in those hard, uncomfortable chairs![6]

Emotional adjustment to loss *is* a difficult process, and it occurs in some degree at some time in the life of virtually every person with a disability and everyone close to her/him. Understanding the nature and possible behaviors associated with the process may help guidance staff be more helpful to the student and the family; but basic to that possibility, as always, is a clear understanding of *that individual situation* and the actual source of the problem.

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[6]Reprinted from Buscaglia, Leo. *The disabled and their parents: A counseling challenge.* Thorofare, New Jersey: Charles B. Slack, Inc., 1975, p. 138. Reprinted by permission.

ACTIVITY #3: EXAMPLE STUDENT BEHAVIORS

The coordinator will ask discussion questions and offer feedback related to the following situations.

1. Bruce, 16, has cerebral palsy of the athetoid type. He is a quadriplegic with moderate involvement, is able to walk alone, and has above-average intelligence. In a career guidance class he has missed several assignments on seeking information from local employers. He says, "I don't want to call them. I just don't know what I want to do. I don't even know what to ask."

2. Ken is a 17-year-old who has lost his leg at the knee in a motorcycle accident. Two days after the accident he says, "I gotta be out of the hospital in two weeks for the start of baseball practice!"

3. Carlos, 8, has been blind from birth and never encouraged by his parents to be independent. He is very passive. One day while talking to his counselor he says, "I lost my social studies assignment on the way to school this morning. Last night I lost a record--it broke." Later he says, "My dog got lost a couple of weeks ago."

4. Terry is 15 and has sickle cell disease. She has been hospitalized several times for sudden onset anemia and other complications, and though she once participated in several active sports, her physical activities are now limited. She has been uncooperative and quarrelsome with her teachers and friends. To one teacher, a former favorite, she says, "You just want to make me good at books so I'll fit better in your nice white world."

5. Rebecca, 17, has epilepsy, fairly well controlled, but occasionally she has grand mal seizures. Talking to the career center specialist she says, "I'd like to go into medicine, but I'm afraid I'd upset patients or not be able to use equipment and stuff well enough. Maybe in some specialties that wouldn't matter though."

6. Ben, 12, has muscular dystrophy and is no longer able to attend school. He refuses to see the itinerant teacher and insists, "There's no use in my learning anything. I'm just going to die, get weaker and weaker until I'm dead. Don't even let that teacher in the front door!"

Name _____

EVALUATION #3

Below are the questions for this evaluation. For A, four of the five stages must be named correctly; for B, both of the responses to the selected question must be correct or acceptable for you to achieve this objective.

A. List the five basic stages of the model of adjustment described in the module text.

B. Below are three descriptions of behaviors guidance personnel might encounter in students with disabilities. You are to answer the questions under one of these descriptions, whichever you choose.

1. Ann is 15, congenitally blind, and shows little desire to succeed at anything. When encouraged to try anything new, her response is "I don't want to. It's too much trouble," and an expressionless stare.

a. What stage does this behavior best reflect?

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

2. Chin, 10, has been profoundly deaf since birth and his speech is difficult to understand. He does not want to enter a regular classroom for any subject, though he lipreads well. He says, "The work will be too hard for me. I don't know the teacher--I'll bet she's hard. I'll bet she's the hardest teacher in the school."

a. What stage does this behavior best reflect?

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

3. Lois, 12, has recently had polio and is paralyzed from the waist down. She is not expected to walk again. She insists, "I can walk. I know I can walk. I know I can stand as straight as anyone. All it takes is to try hard enough."

a. What stage does this behavior best reflect?

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

PROBLEMS FACING THE DISABLED

Problems of the Disabled in a Non-Disabled World

The problems faced by those with disabilities are not all related to their own emotional development. The environments of such people throw into their paths daily difficult situations over which they have little or no control. These situations are of two types: (1) physical and architectural obstacles and (2) social difficulties.

Physical and Architectural Obstacles

Problem-Causing Structures

Physical and architectural structures are frequently constructed with no thought of those other than "normal" people in mind. Cynthia Dickinson points out in *The Disabled and Their Parents: A Counseling Challenge:*

> ...I am really angry at modern architects.... Sublime examples of modern architecture abound on every university campus designed by unthinking men with two good legs and two good eyes who have never had to consider the mechanics of getting themselves from one place to another. I wish that every architect who has ever designed a round building would have to try to navigate in it blindfolded....[7]

Structures such as stairways and steps, revolving doors or doors which require a strong push to open, and narrow lavatory cubicles pose no problem to those who move easily, but may be utterly unusable to a person in a wheelchair. Similarly, thick carpets make moving difficult for wheelchairs; decorative cobblestones can interfere with the mobility of those with chairs or crutches and also with that of the visually impaired. Any low-hanging object, such as a hanging planter, can also cause difficulty for the visually impaired. The hard-of-hearing cannot perceive doorbells, telephones, or warning sirens unless visual signals accompany their sounds.

[7] Reprinted from Buscaglia, Leo. *The disabled and their parents: A counseling challenge.* Thorofare, New Jersey: Charles B. Slack, Inc., 1975, p. 252. Reprinted by permission.

Social Difficulties

We have already discussed the meaning of "disability" as opposed to "handicap." As Maria French pointed out, part of what makes a condition *handicapping* is the attitudes of those around the person to the disability. If these attitudes are pitying, denigrating, condescending, and if they form the main emotional basis of the person's life, then s/he cannot help but absorb this type of "reflection of the self" into his/her self-image. Frances Warfield, author of *Cotton in My Ears*, says of her family's attitude toward physical imperfection:

Attitudes of Family

> I mustn't let on I couldn't hear perfectly. People didn't like it. It made them scornful like [my sister] Ann or exasperated like Aunt May or Aunt Harriet when they called and I didn't answer right away.[8]

Pity and condescension may show in the family's behavior as overprotection or impatience with the child's efforts at accomplishment. Rather than encouraging such efforts, the family may actually restrict the child's activities because they feel the activities are too difficult (e.g., a child in a wheelchair taking a bus to school) or too inconvenient (e.g., a spastic child making a mess of the table while eating).

Attitudes of Society and Strangers

Even if the family and/or others close to the person possess positive attitudes, s/he will still have to face the widespread attitudes of our society as reflected in the reactions of strangers. Raymond Goldman, whose legs were paralyzed when he was 4, writes in his book *Even the Night* of his first day in school:

> ...One of them (the other boys) stopped to look me over... 'This kid can't walk. He says he can crawl real fast though.'
>
> 'I can even crawl up and down steps,' I told them. 'They won't let me crawl here because I'd get dirty.'
>
> The boys began to laugh. I wondered what was funny about that statement. Through my mind flashed the weeks and weeks of efforts before that feat had been

[8] Frances Warfield, *Cotton in My Ears* (New York: Viking Press, Inc., 1948), p. 4.

accomplished. Now my boast--and I had really said it boastingly--was greeted with laughter.

...One of the boys leaned down and touched my leg. He circled it with thumb and forefinger.

'Look how skinny!' he shouted triumphantly. 'I can wrap it with two fingers!'

'Let's see!'

'Sure 'nough!'

'Gee, what skinny old legs!'

A feeling of inferiority began to batter against the bulwark of my illusions. I sensed the ridicule before I comprehended it. I had never been fully conscious of the fact that my legs were emaciated. Now I looked down at them and then at the legs of the other boys. The damnable hammer of comparison beat the truth into my consciousness.... [9]

Other responses, more common to adults than ridicule, are just as effective at denying the humanity of those with disabilities. Louise Baker, a woman with a missing leg, says in her book *Out on a Limb:*

> Whenever I fell, out swarmed the women in droves, clucking and fretting like a bunch of bereft mother hens. It was kind of them, and in retrospect I appreciate their solicitude, but at the time I resented and was greatly embarrassed by their interference. For they assumed that no routine hazard to skating--no stick or stone--upset my flying wheels. It was a foregone conclusion that *I* fell because I was a poor, helpless cripple. [10]

The special problems which everyday situations pose for those with disabilities are often not obvious to those who are physically normal. We hope that spending some time considering the perspectives of those with disabilities will help you better work with their frustrations and problems.

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[9] Raymond Goldman, *Even the Night* (New York: The MacMillan Company, 1947), pp. 35-37.

[10] Louise Baker, *Out on a Limb* (New York: McGraw-Hill Book Co., 1946), p. 22.

ACTIVITY #4

The coordinator will lead an activity focusing on the obstacles faced by a person with a disability. When this is completed, go on to the written evaluation on the next page.

Name _____

EVALUATION #4

Below are questions to be answered for this evaluation. For part A, four of five responses must be acceptable in the coordinator's judgment; in part B, two of the three responses to questions 2, 3a, and 3b must be correct/acceptable according to the coordinator's judgment, based on the appropriateness and completeness of description of the strategies, for you to achieve this objective. "Completeness of description" means specifying the who, why, when, where, and how of your strategy and establishing the logical continuity of your steps.

A. List five physical or architectural obstacles which people with disabilities may encounter. These may be from the text, subsequent discussion, or your own experience. For each obstacle, list the disability or disabilities for which the obstacle would be a problem. Explain why it would be problematic if this is not obvious.

1.

2.

3.

4.

5.

B. Following is a description of three experiences of a ninth grade student during one day. You are to select *one* of these experiences and answer the questions on the next two pages in regard to this experience.

Ellen is a 14-year-old girl who attends Ashburn High School. She is a "thalidomide baby;" due to her mother's use of the drug during pregnancy, Ellen was born with no arms, only vestigial hands at her shoulders, and markedly dwarfed and non-functioning legs. She uses a motorized wheelchair. She exhibits no chronic academic or behavioral problems and her achievement is in the average range.

One day towards the end of school, one of her teachers comes to you in the guidance office and tells you of three experiences which Ellen has told her have taken place that day.

1. That morning, her father had yelled at her during breakfast. He had been trying to make airline travel arrangements for her and found she could not travel unaccompanied and had told her she was "always being a problem, always costing extra money and time, always tying everybody down." When you check Ellen's records, you find no indication that her parents have frequently been neglectful or abusive.

2. The second experience was in a class that morning. Ellen had been turning a corner in a building corridor and had seen three of her classmates laughing and mimicking her, pressing their wrists to their shoulders and fluttering their hands in ridiculing fashion.

3. The third incident was a substitute teacher entering one of her classrooms that afternoon. Upon seeing Ellen, he said, "Good God!" and turned away. He didn't look at her again the entire class hour.

Ellen is quite upset and the teacher would like you to talk to her.

1. Write down the number of the experience you have selected.

2. Name the type of reaction the other person has displayed toward Ellen.

3. Discuss how you would go about handling the situation:
   (a) in trying to help Ellen directly

   (b) in trying to positively influence Ellen's environment

SKILLS FOR DEALING WITH DISABILITIES

Skills Needed by Those with Disabilities

No one has totally avoided difficulty in dealing with others. Everyone has experienced rejection, embarrassment, and the occasional moody or tactless reactions of others. For students with disabilities, however, these reaction patterns may form *most* of their experience with others. This kind of background can be especially detrimental to the development of skills in relating to others.

One set of skills which the disabled need, which is both different from those needed by the non-disabled and basic to ease of communication, is in the area of naming, discussing, and giving information about their disability openly and comfortably.

Skill in Talking Openly about the Disability

Open Communication

The ability to communicate openly about a disability is fundamental to the person's adjustment because most disabilities are, at some point, unavoidably noticeable to others. Often the other sees the disability first and foremost; in fact, sometimes the other sees only the disability and not the human being at all. The person with the disability must acknowledge these realities and deal with them, just as s/he must acknowledge physical limitations. Only if the person is comfortable and open with the fact of the disabling condition--that is, can see it as one aspect out of many which make up his/her "personhood"--can others be influenced to see the whole person too.

Most people with disabilities can perceive from experience the uncertainty and lack of ease others feel. It will often be up to them to dispel that uncertainty by bringing up the topic of the disabling condition, offering appropriate information on its cause, extent, or implications, or openly talking about the other's discomfort. For instance, the

epileptic may volunteer, "I have what is called psychomotor epilepsy. Sometimes I talk strangely and don't remember things. But it passes and all you need to do is wait a minute or two." Being able to choose to do something like this may require the person to first deal with her/his own anger at constant negative or uncomfortable reactions from others. The realization that negative reactions arise from widespread social norms and expectations which are largely unexamined, not from conscious personal intent, is a step toward managing this anger.

Tools of Guidance Staff Members

Among the guidance staff member's most effective tools in helping such students are the abilities to model and to encourage comfortable communication. In order to accomplish this, guidance staff members must behave in a comfortable manner when discussing the disability. They must be able to use the terms descriptive of the condition easily, without pausing or stumbling. They must be able to look at and touch the student without hesitation or embarrassment. It is especially helpful if they can model using humor appropriately to ease tension and facilitate discussion of the condition -- or on occasion to serve as a rude awakening. Louise Baker talks of a woman stranger who said to her:

> 'My poor girl, I see you've lost your leg.' That's the opportunity for the touche, 'How careless of me!' [11]

Practicing Skills

The next activity will focus on these skills. First a model interaction will be presented in which the "guidance staff person" uses a variety of skills. After this the coordinator will help you identify the specific skills displayed. Then you will have an opportunity to practice using these skills yourself in role-play situations, and receive feedback from other participants.

[11] Louise Baker, *Out on a Limb* (New York: McGraw-Hill Book Co., 1946), p. 97.

ACTIVITY #6: ROLE-PLAYING SKILLS
IN OPEN COMMUNICATION ABOUT A DISABILITY

In the model role-play you are about to observe, watch for the presence of the following nine skills in the "guidance staff member's" behavior.

1. Using terms descriptive of the condition without hesitation or stumbling

2. Looking straight into the eyes of the student with the disability

3. Touching the student comfortably and without hesitation when appropriate

4. Looking straight at the disabled parts of the student's body, if these are apparent

5. Touching the disabled parts of the body, if appropriate (Caution: Sensitivity to the student's readiness to have the disabled part touched is important.)

6. Questioning the student without hesitation or embarrassment concerning the full extent of her/his limitations and difficulties related to the disability

7. Focusing on the student's strengths, while at the same time acknowledging his/her limitations

8. Helping the student compensate for lacks in functioning or communicating, frankly and without excessive solicitousness (i.e., guiding a blind boy past an obstacle, telling a speech-impaired student you don't understand her and would like her to repeat more slowly what she said, etc.)

9. Using humor appropriately (Caution: Great care and tact are needed in sensing what kinds of humor are appropriate and what kinds may be offensive. When in doubt, leave it out!)

EVALUATION #5: ROLE-PLAYS

Divide into groups of three (with some of four if needed). The coordinator will give you a set of three (or four) role-plays plus observer checklists like the ones found on the next two pages. Two people should begin the first role-play, while the other(s) use(s) the Evaluation Checklist and note(s) specific points for feedback. The observer(s) should evaluate only the person playing the "guidance staff member," not the one playing the "student."

The observer(s) should look for particular skills displayed by the "guidance staff member" in discussing a disability openly. The nine skills are listed on the first page of the Evaluation Checklist. The observer(s) must indicate that at least five of these skills are displayed for the "guidance staff member" to achieve the objective. When the role-play is over, the observer(s) and the "student" should give feedback to the "guidance staff member" regarding effective or ineffective behaviors. Remember that this feedback may be as valuable, or even more valuable, to the participant as merely knowing she/he displayed five skills and achieved the objective. The checklist has a "comments" section where points to cover in the feedback may be recorded.

When one role-play is completed, a different pair should begin the next role-play with the other(s) observing, and so on. No one should play either the "guidance staff member" or the "student" more than once.

When all role-plays are completed, the last page of the Evaluation Checklist should be filled in, detached, and handed to the coordinator. The rest of the checklist may be given to the "guidance staff member" it evaluates.

EVALUATION CHECKLIST

Participants' names

"Guidance staff member":_____

Observer:_____

Did the participant:

1.	Use terms descriptive of the condition without hesitation or stumbling?	Yes___	No___
2.	Look straight in the eyes of the "student with a disability"?	Yes___	No___
3.	Touch the "student" comfortably and without hesitation when appropriate?	Yes___	No___
4.	Look straight at the disabled parts of the "student's" body, if these are apparent?	Yes___	No___
5.	Touch the disabled parts of the body, if appropriate and these parts are apparent?	Yes___	No___
6.	Question the "student" without hesitation or embarrassment concerning the full extent of her/his limitations and difficulties related to the disability?	Yes___	No___
7.	Focus on the "student's" strengths, while at the same time acknowledging his/her limitations?	Yes___	No___
8.	Help the "student" compensate for lacks in functioning or communicating frankly and without excessive solicitousness?	Yes___	No___
9.	Use humor appropriately?	Yes___	No___

Comments

Participants' names:

"Guidance staff member":_____

"Student":_____

Observer:_____

Objective achieved (five skills in open communication about a disability present in role-play):

YES_____ NO_____

APPENDIX

GLOSSARY

Brief definitions of common disabling conditions and common terms

Hearing Impairment

Deaf - Refers to a condition of total functional loss of hearing occurring at birth or before speech and language develop

Deafened - Refers to a condition of total functional loss of hearing occurring since speech and language development

The Conference of Executives of American Schools for the Deaf has made the following classifications:

Congenitally Deaf - Refers to the condition of deafness at birth

Adventitiously Deaf - Refers to a condition of normal hearing at birth followed by deafness later through illness or accident

Hard of Hearing - Refers to a condition of defective but functional hearing, either with or without a hearing aid

Mild Hearing Loss - 20 to 30 decibel loss in the better ear in the speech range of frequencies

Marginal Hearing Loss - 30 to 40 decibel loss

Moderate Hearing Loss - 40 to 60 decibel loss

Severe Hearing Loss - 60 to 75 decibel loss

Profound Hearing Loss - A loss of greater than 75 decibels

Conductive Hearing Loss - One which reduces the intensity of sound reaching the inner ear, due to malformations, broken eardrum, etc.

Perceptive Hearing Loss - One due to damage to the inner ear or the auditory nerve

Central Deafness - A condition owing to some injury or abnormality of the central nervous system

Speech Impairment

Defective Speech - Usually defined as any speech which deviates from the normal so that (a) it lacks intelligibility, (b) possesses markedly unpleasant sound, or (c) is inappropriate to the age level of the speaker. Kirk (1962) categorizes speech defects as follows:

Misarticulation - Articulation defects with functional origin

Dysarthria - Articulation disorders due to cerebral dysfunction, such as cerebral palsy

Dysphonia - Voice disturbances, including faulty phonation or resonation and pitch deviations or no voice

Dysrhythmia - Vocal timing disturbances, as in stuttering

Aphasia - Symbolization and comprehension disorders due to cerebral dysfunction

Dyslogia - Linguistic disturbances, as in mental retardation

Defects Due to Auditory Difficulties

Articulation problems are by far the most common, forming over 60% of all speech defects.

Visual Impairment

Blind - less than 20/200 vision in the better eye after correction or with a field of vision of less than 20°

Partially Sighted - less than 20/70 in the better eye after correction

Refractive Errors -

Hyperopia - Farsightedness (ability to see far objects but not near)

Myopia - Nearsightedness (ability to see near objects but not far)

Astigmatism - A condition due to irregularity in the curvature of the cornea or lens of the eye

Poor Muscle Functioning -

Strabismus - Lack of coordination of eye muscles so that the two eyes do not focus on the same object. The weak eye may turn either in or out. If it turns in, this condition is "crossed eyes."

Heterophoria - Latent muscular weakness; the deviation of the eyes from the correct position for binocular focus is not immediately apparent

Developmental Abnormalities -

Albinism - Absence of pigment from the iris (as well as skin and hair)

Cataract - A condition in which the lens becomes opaque

Brain Dysfunction

Cerebral Palsy - A motor disability caused by a brain dysfunction. The American Academy of Cerebral Palsy defines the condition as "any abnormal alteration of movement or motor function arising from defect, injury, or disease of the nervous tissues in the cranial cavity." Paralysis, weakness, and lack of coordination are characteristic of the condition, which may also involve other mental and/or psychological disabilities of perception, learning, emotions, and speech.

Spasticity, Spastic - A condition characterized by lack of balance between opposing sets of muscles controlling the involved extremity or extremities. Though movements are voluntary they are jerky, spasmodic, and uncontrolled.

Athetosis, Athetoid - A condition characterized by seemingly random, uncontrolled, and irrhythmical movements, including a lurching, writhing walk. Facial grimaces are often extreme.

Ataxia, Ataxic - A condition characterized by lack of balance and muscular coordination

Tremor - A condition characterized by fairly continuous, even vibrating movements of the affected extremities

Rigidity - A condition characterized by diminished ability to move

Monoplegia - Involvement in one limb

Hemiplegia - Involvement of one side of the body (arm and leg)

Paraplegia - Involvement of both legs only

Triplegia - Involvement of three limbs, usually two legs and one arm

Quadriplegia - Involvement of all four limbs, and often the head and trunk as well

Other Common Conditions

Allergies - Abnormal reactions to particular substances, such as drugs, pollen, dust, foods, plants, insect bites. Bronchial asthma and hay fever are classified as allergic reactions.

Arthritis - Inflammation and swelling in the joints

Congenital Deformities - Structural defects present since birth, including

Scoliosis - Lateral curvature of the spine

Club Feet - Feet characterized by ankles turned inward and downward

Cystic Fibrosis - A congenital, inherited disease affecting the pancreas, respiratory system, and sweat glands, and characterized by thick, gluey mucous and frequent respiratory infection

Diabetes - A condition characterized by the inability of the body's cells to obtain or use adequate amounts of the hormone insulin, which is produced by the pancreas and enables the cells to absorb and metabolize glucose.

Epilepsy - A condition resulting from cerebral dysfunction and characterized by seizures, often convulsive

Grand Mal Seizures - True convulsions in which the individual falls and loses consciousness

Petit Mal Seizures - A condition characterized by loss of consciousness (usually brief), staring and twitching of the eyelids, but without bodily convulsions

Psychomotor Epilepsy - A condition characterized by short periods of amnesia, mumbling, dropping things, and staring

Jacksonian Epilepsy - A condition characterized by convulsion of one side of the body, beginning at the foot and working up to the arm

Hemophilia - An hereditary condition in which the blood clots and seals off wounds very slowly or not at all

Multiple Sclerosis - A poorly understood disease of the central nervous system characterized by progressive weakness, paralysis, and tremor. No cure is known.

Muscular Dystrophy - Several types of progressive weakening of muscular strength. No cure is known and the majority of afflicted children die of respiratory disease at an early age.

Osteomyelitis - Infectious inflammation of the bone marrow

Poliomyeletis - A virus-caused disease resulting in muscle weakness and paralysis because of damage to the nerve cells in the spinal cord

Rheumatic Fever - An infectious inflammatory disease with fever and pain in the joints, frequently the cause of a weakened heart

Sickle Cell Disease - An inherited condition found in the black population but rarely in other racial groups, in which the red blood cells have decreased ability to change shape and flow easily through small veins and capillaries; the average life span of the cells is also decreased. The disease causes loss of energy and a tendency to severe respiratory illness, pain, disease of various organs, and the onset of severe (fatal if untreated) anemia.

Spina Bifida - An open defect in the spinal canal, resulting in paralysis of the lower limbs and trunk and loss of excretory control

Traumatic Conditions - Amputation, injury, fracture, or burns

Tuberculosis - An infectious disease characterized by the development of tubercules in the lungs and resulting symptoms of respiratory disease

Abseon, A. C., Bouie, N., & Haas, J. *A primer on due process--Education decisions for handicapped children.* Reston, Va.: Council for Exceptional Children, 1975. 72 pp.

Details the rights of children and their parents in the educational decision-making process, including access to all records, the right to participate in the placement decision and the opportunity for a hearing if they are not in agreement with the education agency's decision.

A continuing summary of pending and completed litigation regarding the education of handicapped children. Reston, Va: Council for Exceptional Children, 1975.

Current information on the status of litigation in the areas of right to education, right to placement and right to treatment. Over 50 cases, pending or completed, are summarized. This eighth edition contains all relevant texts and commentaries from previous editions.

Black, Eugene E., M.D., & Nagel, Donald A., M.D. Eds. *Physically handicapped children: A medical atlas for teachers.* New York: Grune & Stratton, Inc., 1975. 304 pp.

This book offers educators a deeper view into the medical aspects of physical disabilities than more general texts on the subject. It begins with a chapter on basic parts and terms of the nervous and musculoskeletal systems, and includes a chapter on parent counseling. It defines conditions; examines their causes, development, symptoms, medical treatment procedures, and prognosis; and in some cases discusses educational implications. Though it omits detailed discussions of a few common physical disabilities, such as tuberculosis and multiple sclerosis, it is a thorough and up-to-date source of medical knowledge for the non-physician.

Buscaglia, Leo. *The disabled and their parents: A counseling challenge.* Thorofare, N.J.: Charles B. Slack, Inc., 1975. 393 pp.

This book covers every imaginable aspect of the process of counseling those with disabilities: discussions of attitudes and strategies; chapters written by those with disabilities and by parents describing their experiences and insights; a literature review; chapters on the special concerns of those with disabilities, such as legal rights and sexual problems; and consideration of behavior modification and the team approach to counseling The experience of disability is examined in depth, with extensive examples and insightful discussion of the many small but significant ways in which those with disabilities are influenced toward growth and acceptance or toward stagnation and despair.

Goffman, Erving. *Stigma--Notes on the management of spoiled identity.* Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963. 147 pp.

This book examines the life situations and behavior of all those who deviate from the "normal" for any reason, whether by defect of body, character, or race/nation/religion. It develops a theory and language for the common aspects of those situations under three major headings: stigma and social identity, information control and personal identity, and group alignment and ego identity. A fourth chapter, "The Self and Its Other," deals briefly with the response of stigmatized individuals to their particular

situation in terms of the needs developed earlier: for the discredited (one whose stigma is known), tension management; for the discreditable (one whose stigma is not known), information management.

Gowan, John C.; Demos, George D.; and Kokaska, Charles J. *The Guidance of Exceptional Children,* 2nd edition. New York: David McKay Co., 1972.

This collection of readings includes guidance and counseling efforts with children and adolescents who are underachievers, emotionally disturbed, mantally retarded, blind, deaf, and physically handicapped.

Kirk, Samuel A. *Educating Exceptional Children,* 2nd edition. Boston: Houghton-Mifflin Co., 1972. 478 pp.

This book utilizes the unifying concept of "discrepancies in growth and development" to examine the entire range of exceptionality. The kinds of exceptionality examined are: giftedness; mental retardation, especially educable and trainable levels; deafness; impaired hearing; blindness; partial sight; speech handicaps; cerebral palsy; orthopedic and special health problems; behavior deviation and specific learning disabilities. Functional and medical descriptions and terminology, child development patterns, research data, educational suggestions for both integrated and special class situations, description of special student and teacher equipment, and extensive references are included.

Kübler-Ross, Elizabeth. *On death and dying.* New York: MacMillan Publishing Company, Inc., 1969. 260 pp.

This book sets forth a model of the typical stages of psychological adjustment to impending death (denial and isolation, anger, bargaining, depression, acceptance), together with a number of interviews with dying patients and a plea for greater sensitivity on the part of all professionals to the needs of the dying for communication and humane treatment. Module authors feel it has applicability to any profound loss situation, as well as being a thorough explanation of this particular human situation.

Love, Harold D. *Educating exceptional children in regular classrooms.* Springfield, Illinois: Charles C. Thomas, Publisher, 1972. 235 pp.

This book deals with all types of exceptional children (including the gifted), focusing on "...the child whose problems can be seen as relatively mild...." The types of exceptionality are classified as mental retardation, giftedness, partial sight, partial hearing, speech handicaps, physical handicaps, social and emotional maladjustments, learning disabilities, and special health problems. The emphasis throughout is on the possibilities for and the desirable outcomes of "mainstreaming" all but the most markedly exceptional child.

McAlees, Daniel C. "The School Counselor and the Handicapped." *Focus on Guidance,* 4(4), 1971. 9 pp.

This article discusses the development of, and hindrances to, the idea of equal educational opportunity for all children, including those with handicaps. It asserts that the client's independence is the chief goal of counseling, and it discusses counselor attitudes and behaviors which promote this goal. It also contains a good general description of the widely available types of service agencies and programs for those with handicaps which are especially useful for counselors to know.

McDaniel, James W. *Physical disability and human behavior.* Elmsford, New York: Pergamon Press, Inc., 1969. 231 pp.

This book thoroughly covers theory and research on the psychological aspects of physical disability, including theoretical foundations, attitudes toward those with disability, emotional factors in illness and disability, sensory and perceptual processes in disability, motivation, and regulation and control of behavior.

Spencer, J. S., Perkins, D. C., & Lewin, M. *A survey of medicine and medical practice for the rehabilitation counselor.* Washington, D.C.: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Services, 1966. 171 pp.

This document offers an introduction to the structure of medical practice in the United States, as well as information on major disabling diseases and conditions. Each condition description concludes with a section on vocational implications, sometimes including specific job titles. Appendices include case studies, lists of professional societies and health agencies, and figures on major disabling conditions of persons rehabilitated in the U.S. during fiscal year 1963-64. Suggested readings conclude each chapter.

Wright, Beatrice A. *Physical disability--A psychological approach.* New York: Harper and Brothers, Publishers, 1960. 408 pp.

This volume covers, in depth and with extensive examples from the life experiences of people disabled by different conditions, the psychological aspects of physical disability from the point of view of those with disabilities, of others, and of factors in rehabilitation. Main themes are status, frustration and uncertainty, value changes in acceptance of disability, development of the self-concept and perception of interpersonal relations, the adolescent with a physical disability, grievances and gratifications in everyday relationships, sources of attitudes toward persons with atypical physique, training in social skills, the parent as key participant, motivating children in the rehabilitation program, the client as co-manager in his rehabilitation, and an assessment of the field of somatopsychology (the influence of physique upon a person's psychological situation).

Audio Cassett Program: Jones H., & Farr, R. *Realities of the physically handicapped.* Produced by Instructional Media Inc., 8141 E. 44th St., Tulsa, Oklahoma 74145.

This program was developed by two "enablers" for physically limited students at De Anza College in Cupertino, California, both of whom have disabling conditions themselves. It covers a number of attitudinal and environmental problems those with disabilities face, among them accepting a disability; how society relates to the disabled; information seeking; defining jargon; architectural barriers and housing; transportation for the handicapped; activities of daily living; sexuality, marriage, and parenthood; and success stories and recreation. (6 cassettes)

If you feel you want to expand your familiarity and feeling of ease with those with disabilities, there are many agencies you can contact:

(a) State departments of rehabilitation;

(b) State education departments, office of special education;

(c) Local School district special education programs;

(d) Local public or private associations or chapters of associations for specific disabling conditions, usually listed in the Yellow Pages under "Social Service and Welfare Organizations" or similar titles;

(e) Local residential institutions for the physically or orthopedically disabled;

(f) University special education teacher, rehabilitation counselor, or school counselor training programs;

(g) Hospitals, especially hospital social workers; and

(h) Local school special education teachers or programs.

The Council for Exceptional Children, 1920 Association Drive, Reston, Virginia 22091 serves as the ERIC Center for documents on exceptional children, and in addition has established its own information center covering the entire range of materials concerned with exceptionality. Books, monographs, audio tapes, and computer searches of research programs, legislation, policy, and curricula are available through its Information Services and Publications Department.

You might also check with the Physical Education and Recreation for the Handicapped Information and Research Utilization Center, 1201 Sixteenth St., N.W., Washington, D.C. 20036. Many of the materials described in this organization's catalog have far wider applicability than might be expected from this source. Books, films, reports, and monographs cover such topics as eliminating architectural barriers, parental attitudes, activities for students with specific disabilities, and independent living.

Other organizations you might want to contact are listed on the following pages.

DIRECTORY OF ORGANIZATIONS RELATED TO INDIVIDUALS WITH PHYSICAL DISABILITIES

Alexander Graham Bell Association for the Deaf
3417 Volta Place, N.W.
Washington, D.C. 20007

American Association for Rehabilitation Therapy, Inc.
P.O. Box 93 / North Little Rock, Ark. 72116

American Association of Workers for the Blind, Inc.
1511 K Street, N.W.
Washington, D.C. 20005

American Cancer Society, Inc.
219 East 42nd Street
New York, NY 10017

American Foundation for the Blind, Inc.
15 West 16th Street
New York, NY 10011

American Orthotic and Prosthetic Association
1440 N Street, N.W.
Washington, D.C. 20005

American Physical Therapy Association
1156 15th Street, N.W.
Washington, D.C. 20005

American Podiatry Association
20 Chevy Chase Circle
Washington, D.C. 20015

American Printing House for the Blind, Inc.
1839 Frankfort Avenue
Louisville, Kentucky 40206

American Speech and Hearing Association
9030 Old Geo'town Rd.
Washington, D.C. 20014

The Arthritis Foundation
1212 Avenue of the Americas
New York, NY 10036

Boy Scouts of America, Scouting for the Handicapped Division
Boy Scouts of America
North Brunswich, N.J. 08902

Bureau of Education of the Handicapped, U.S. Office of Education
400 Maryland Ave., S.W.
Washington, D.C. 20202

Council of Organizations Serving the Deaf
P.O. Box 894
Columbia, MD 21044

The Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091

Epilepsy Foundation of America
1828 L Street, N.W.
Washington, D.C. 20036

Federation of the
Handicapped, Inc.
211 West 14th Street
New York, NY 10011

Girl Scouts of the U.S.A.,
Scouting for Handicapped
Girls Program
830 Third Avenue
New York, NY 10022

ICD Rehabilitation and
Research Center (Formerly
Institute for the Crippled
and Disabled
340 East 24th Street
New York, NY 10010

The Industrial Home
for the Blind
57 Willoughby Street
Brooklyn, NY 11201

International Association
of Laryngectomees
219 East 42nd Street
New York, NY 10017

International Association of
Rehabilitation Facilities, Inc.
5530 Wisconsin Avenue #955
Washington, D.C. 20015

Library of Congress Division
for the Blind and Physically
Handicapped
Washington, D.C. 20542

Muscular Dystrophy
Associations of America, Inc.
810 Seventh Avenue
New York, NY 10019

National Association
of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910

National Association of
Hearing and Speech Agencies
814 Thayer Avenue
Silver Spring, MD 20910

National Association of the
Physically Handicapped, Inc.
6473 Grandville Avenue
Detroit, MI 48228

National Center for A Barrier
Free Environment
7315 Wisconsin Avenue
Washington, D.C. 20014

National Congress of
Organizations of the
Physically Handicapped, Inc.
7611 Oakland Avenue
Minneapolis, MN 55423

National Easter Seal Society
for Crippled Children
and Adults
2023 West Ogden Avenue
Chicago, IL 60612

National Federation of the
Blind
Suite 212, 1346 Connecticut
Ave., N.W./ Wash., D.C. 20036

The National Foundation/
March of Dimes
1275 Mamaroneck Ave.
White Plains, NY 10605

The National Hemophilia
Foundation
25 West 39th Street
New York, NY 10018

National Inconvenienced
Sportsmen's Association
3738 Walnut Avenue
Carmichael, CA 95608

National Information Center for the Handicapped, Closer Look
P.O. Box 1492
Washington, D.C. 20013

National Industries for the Blind
1455 Broad Street
Bloomfield, NJ 07003

National Multiple Sclerosis Society
257 Park Avenue South
New York, NY 10010

National Paraplegia Foundation
333 N. Michigan Avenue
Chicago, IL 60601

National Rehabilitation Counseling Association
1522 K Street, N.W.
Washington, D.C. 20005

National Society for the Prevention of Blindness, Inc.
79 Madison Avenue
New York, NY 10016

National Therapeutic Recreation Society (A Branch of the National Recreation and Park Association)
1601 North Kent Street
Arlington, VA 22209

Paralyzed Veterans of America
7315 Wisconsin Ave.
Suite 301-W / Wash., D.C. 20011

The President's Committee on Employment of the Handicapped
Washington, D.C. 20210

President's Committee on Mental Retardation
7th and D Streets, S.W.
Washington, D.C. 20201

Professional Rehabilitation Workers with the Adult Deaf, Inc.
814 Thayer Avenue
Silver Spring, MD 20910

Rehabilitation International USA
17 East 45th Street
New York, NY 10017

Rehabilitation Services Administration
330 C Street, S.W.
Washington, D.C. 20201

Sister Kenny Institute
1800 Chicago Avenue
Minneapolis, MN 55404

United Cerebral Palsy Associations, Inc.
66 East 34th Street
New York, NY 10016

United Ostomy Association, Inc.
1111 Wilshire Blvd.
Los Angeles, CA 90017

COORDINATOR'S GUIDE

ENHANCING UNDERSTANDING OF STUDENTS WITH PHYSICAL DISABILITIES

Developed by the National Consortium on Competency-based Staff Development, in cooperation with the American Institutes for Research, under support by the United States Office of Education, Department of Health, Education, and Welfare under Part C of the Vocational Education Act of 1963.

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INTRODUCTION

This module is intended as a tool for you to use in guiding the learning of participants interested in the guidance and counseling of students with physical disabilities. We assume that you, as workshop coordinator, have some actual experience in counseling those with physical disabilities, and we encourage you to use your experience in making the materials meaningful to the participants. It will be useful for you to become very familiar with the content of this module so that you can decide if you want to use all or parts of it or to adapt some of it to the particular conditions of your workshop.

This coordinator's guide includes an outline of workshop activities, suggestions for introducing the module to the participants, guidelines for leading discussions, evaluation criteria for each objective, and suggestions for wrapping up the day's activities. In addition to this guide, you should provide for use in the workshop:

- Module texts for each participant
- Blackboard
- Film projector for 16-mm sound film, "A Matter of Inconvenience," produced by the Stanfield House
- Slide projector

In general, this workshop is meant to be *participatory*. Participants often have much to teach each other, and it is quite appropriate for you to encourage discussion whenever it seems needed or useful.

MODULE GOAL AND OBJECTIVES

Module Goal

This module is designed for use by guidance personnel in school settings, grades K-12, or participants in pre-service training programs. Such personnel may include professional, paraprofessional, and support staff, or anyone else who is part of the team providing guidance services to students with physical disabilities.

The goals of this module are:

1. to help participants become aware of widespread attitudes and behaviors toward people with physical disabilities, including the attitudes and behaviors of society as a whole, those which may occur in guidance situations in particular, and those which may exist within themselves;

2. to help participants become aware of the perspectives held by people with physical disabilities regarding the physical and social environments in which they live; and

3. to help participants practice and improve skills associated with open and comfortable communication about disability.

Module Objectives and Criteria for Achievement

Upon successful completion of this module, you will be able to:

Objective 1. Classify example statements by guidance personnel according to three negative assumptions which may exist in their attitudes toward students with physical disabilities, and write alternative statements which do not reflect such assumptions.

Successful achievement of this objective will require you to correctly answer six out of eight questions about hypothetical statements by guidance personnel. Four questions are presented for each of two statements. The first questions require you to identify, by number, one of the three negative assumptions concerning students with physical disabilities. The second questions require you to list the facts expressed in the hypothetical statement. For the third questions, you must underline those parts of the statement that express the assumption. The last questions ask how the statement could be revised to include the facts and not the assumption.

Objective 2. Identify your own attitudes toward people with physical disabilities, in hypothetical situations and in situations from your own experience.

Successful achievement of this objective will require rating your attitudes in six situations involving individuals with disabilities, according to a self-assessment guide in the module.

Objective 3. List the basic stages of psychological adjustment to physical disability; classify examples of student behavior according to the appropriate stage; and describe a response a guidance staff member could make.

Successful achievement of this objective will require correctly listing four of the five stages of adjustment to disability discussed in the module, classifying one statement of student behavior according to the model, and writing an appropriate suggested response for the guidance staff member, including an explanation of why it is appropriate.

Objective 4. A) List physical obstacles faced by students with physical disabilities.

Successful achievement of this objective will require correctly listing four physical obstacles from those described in the text, identified during subsequent discussion, or known to the participant from her/his own experience, and naming the physical condition(s) this obstacle affects (if this is not obvious).

B) Identify two guidance approaches to help alleviate social problems students with physical disabilities might encounter.

Successful achievement of this objective will require describing in writing how you would respond to a hypothetical problem situation. The description should include acceptable versions of two of the following: 1) an identification of the social problem to overcome (e.g., pity, embarrassment, etc.); 2) a suggestion for dealing with the student directly; or 3) a suggestion for dealing with the student's environment.

Objective 5. Demonstrate behaviors related to open and comfortable communication about physical disability.

Successful achievement of this objective will require performing five of nine such behaviors during a role play of a guidance staff member and a handicapped student. Performance will be checked by an observer.

WORKSHOP ACTIVITIES AND DURATION

Cumulative duration		
	15'	Introduction
	10'	Film
25'	25'	
		Objective 1
	15'	Text or lecture
	30'	Discussion
	20'	Evaluation
1 30'	1 05'	
		Objective 2
	5'	Text or lecture
	10'	Slides/self-assessment
	15'	Discussion
2 00'	30'	
		Objective 3
	15'	Text
	20'	Discussion
	15'	Evaluation
2 50'	50'	
		Objective 4
	5'	Text
	45'	Presentation/discussion
	20'	Evaluation
4 00'	1 10'	
		Objective 5
	10'	Text
	20'	Model role-play/discussion
	1 00'	Role-plays/evaluation
5 30'	1 30'	
5 45'	15'	Wrap-up

It is suggested that a 30 min. lunch break and two 15 min. coffee breaks be taken during the day. Convenient breaking times are coffee after Objective 2, lunch after Objective 3, and coffee after Objective 4 activities. The workshop's total duration will then be 6 hr. 45 min.

Please note that these times are only guidelines.

NOTES TO USERS

This module is concerned with the most basic level of interaction between the counselor and the person with a physical disability: the feelings and unconscious assumptions that the counselor (and the person too, for that matter) may bring to the situation.

The module is most appropriately used with counseling staff who have not worked with persons with disabilities before, although portions could be used with more experienced staff as individual activities or to enhance a workshop on more advanced topics. For example, Activity #4, in which the coordinator asks participants to picture themselves as paralyzed in one arm and both legs, can give participants at any level a new perspective on the physical and psychological difficulties faced by those with disabilities.

There are several ways the module might be presented. The outline provided is for a one-day workshop of approximately 6 hours. The activities could also be spread over several weeks of meetings, perhaps working through one objective per meeting. In this case the evaluation of an objective could be completed either at the end of the meeting or at the beginning of the next meeting.

The module is written to be complete as it stands (with some necessary visual aids). However, many activities could be used to enrich learning. Participants or speakers who have physical disabilities themselves and were comfortable about discussing them could be invited to speak on or react to module topics or topics of their choice. Learners could be asked to do research on physical or psychological aspects of particular disabilities. Perhaps appropriate situations for individual or group observation could be arranged.

Of course, the coordinator is free to adapt, add to, or eliminate any activities based on his/her judgment and skills. If module activities seem too "paper-and-pencil" oriented, verbal situations and responses may be substituted. For example, the self-assessment in Activity #2 could be read aloud by the coordinator to stimulate discussion of each point. Activities may be cut short or extended, depending on participant interest or contributions. As long as these changes increase learning, there is no reason to avoid them.

To sum up, this module is best used as a framework for learning. The coordinator's judgment as to length and topics of activities, order of presentation, and use of supplementary activities is the best guide in adapting the module to a particular situation.

15' Introduction

This period can begin with introductions of yourself and all participants to one another by name, institution, and job function. Name tags are helpful if everyone does not know everyone else. You may want to ask participants to state why they chose this topic for study. Then go over the outline of the day's activities, indicating when lunch and coffee breaks will be taken. Ask participants to read over the module introduction, goal and objectives, and glossary before showing the film, and ask for comments. Then begin the film.

10' Film, "A Matter of Inconvenience"

OBJECTIVE 1

15' Text or Lecture

Ask participants to read the text of their modules for Objective 1. Alternatively, prepare an outline as the basis for a lecture on the same topics.

30' Discussion

When all participants have finished reading or the lecture is concluded, begin Activity 1 on the next page. Listed are six statements that might be made by guidance personnel. The participants will find these statements on page 18 in their texts. Read the statements to the group. Each statement reflects one of the three negative assumptions discussed in the text; these are given at the top of the page. Use the questions under each statement to guide the discussion. Sample responses are indicated for each question; use these and/or any others you like to stimulate participants' thinking. Remember that asking or observing a student is almost always possible but not always a good approach to finding the facts; encourage varied responses. The purpose of this discussion is to help the participants become clear as to what part of the statement is fact and what is assumption or elaboration. It is also important that one or more participants develop effective alternative statements that state just the facts and suggest some strategy by which the real significance of the facts can be established. If it seems necessary, you can shorten the activity by stopping after any statement in the list.

COORDINATOR'S GUIDE

ACTIVITY #1: EXAMPLE STATEMENTS BY GUIDANCE PERSONNEL

Assumptions

1. All mental, emotional, and learning problems exhibited by a student with a physical disability are directly related to her/his disability.

2. The same sequence of course work, the same kinds of career plans, and the same limitations on life management and leisure goals and activities are appropriate for all students possessing a similar type and degree of physical disability.

3. Students with physical disabilities, especially those with great involvement, have no needs other than those directly related to their disabilities.

Statements and Discussion Questions

1. A counselor says to a colleague, "This boy's got problems. He hasn't really got any friends. His self-consciousness about his stuttering must color his whole life."

a. What facts about the situation does the statement reveal?

That he has a problem: no friends.

b. Which of the three negative assumptions would you say it reflects?

#1

c. Which specific parts of the statement express the underlying assumption?

"His self-consciousness about his stuttering must color his whole life." The specific assumption is that he is self-conscious.

d. What other possible causes could the student's behavior have?

Lack of exposure to social skills within family

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

One way is to ask his teachers if he seems self-conscious while speaking in class.

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

"This boy's got problems. He hasn't really got any friends. I wonder how self-conscious he might be about his stuttering."

2. A guidance staff member says to a teacher, "Maria's muscular dystrophy has finally confined her to bed. I advised her parents not to let her know much about what's going on in school; I think it would just hurt her to hear what she's missing."

a. What facts about the situation does the statement reveal?

Maria's muscular dystrophy has confined her to bed.

b. Which of the three negative assumptions would you say it reflects?

#3

c. Which specific parts of the statement express the underlying assumption?

"I advised her parents not to let her know much about what's going on in school; I think it would just hurt her to hear what she's missing."

d. What other student needs might be present here, unrelated to the disability?

The need to stay in contact with her real and familiar world, not to feel isolated.

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

One way is to ask Maria if she wants to know what's going on.

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

"Maria's muscular dystrophy has finally confined her to bed. I advised her parents to ask her now and then if she likes hearing about school activities."

3. A counselor says to a student, "I think, Sally, we should choose music courses for your fine arts requirement. I know you can see a little, but I don't think you could succeed in an art course."

a. What facts about the situation does the statement reveal?

Sally can see a little; she has a requirement in fine arts.

b. Which of the three negative assumptions would you say it reflects?

#2

c. Which specific parts of the statement express the underlying assumption?

"...I don't think you could succeed in an art course."

d. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

One way is to find out what art courses (such as weaving) utilize some senses other than vision.

e. How could this statement be changed so it states the same facts but does not express any negative assumption?

"Music courses would fulfill your fine arts requirement, Sally, and perhaps for some art courses you don't need to see well."

4. A secretary in the guidance office says to another staff member, "Sherry's sure not a very energetic girl. I guess being blind really limits her confidence in her ability to move--because even a small movement may mean she gets hurt or bumped or she trips or something."

a. What <u>facts</u> about the situation does the statement reveal?

Sherry's blind and not very energetic; even a small gesture can cause her to get hurt.

b. Which of the three negative assumptions would you say it reflects?

#1

c. Which specific parts of the statement express the underlying assumption?

"I guess being blind really limits her confidence in her ability to move"

d. What else could cause the student's behavior?

Diabetes

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

Ask Sherry how she feels physically.

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

"Sherry's sure not a very energetic girl. Being blind may limit her confidence, or she may have some other health problem. I should consult her doctor."

5. A guidance staff member says to a teacher, "Cindy came in this morning and said Walt tried to kiss her. She was really upset; his paralysis and drooling made her sick. How could he even think about touching such a pretty girl!"

a. What <u>facts</u> about the situation does the statement reveal?

Walt is paralyzed and drools (probably cerebral palsy); he tried to kiss Cindy and it upset her.

b. Which of the three negative assumptions would you say it reflects?

#3

c. Which specific parts of the statement express the underlying assumption?

"How could he even think about touching such a pretty girl!"

d. What other student needs might be present here, unrelated to the disability?

The need for sexual gratification, or at least information

e. How could the guidance staff member go about proving or disproving the parts of the statement that express the assumption?

One way is to ask him what kind of information on human sexuality he's received.

f. How could this statement be changed so it states the same facts but does not express any negative assumption?

"Cindy came in this morning and said Walt tried to kiss her. She was really upset; his paralysis and his drooling made her sick. Sexual matters may be hard for him to handle; maybe if I bring the subject up we can get some things into the open."

6. A career center staff member says to a parent, "I don't see how Pat could become a nurse with her hearing problem. She couldn't hear patients call for help or use equipment which transmits information by sound. I think we should skip that option as a possible career for her."

a. What facts about the situation does the statement reveal?

Pat is hearing impaired; nursing is being discussed as a possible career for her.

b. Which of the three negative assumptions would you say it reflects?

#2

c. Which specific parts of the statement express the underlying assumption?

"I don't see how Pat could become a nurse with her hearing problem. . . . I think we should skip that option as a possible career for her."

d. How could the guidance staff member go about proving or disproving the part of the statement that express the assumption?

One way is to contact the state rehabilitation office or nursing training programs to see what the difficulties for, and adaptations to, a hearing-impaired nurse might be.

e. How could this statement be changed so it states the same facts but does not express any negative assumption?

"I can foresee some difficulties for Pat in trying to get into nursing, like hearing patients call for help or using equipment which transmits information by sound. We should look into it further, though."

20' Evaluation

The evaluation for Objective 1 is a written one. Two statements are to be classified and alternate responses written as in the activity. You will need to collect and evaluate these during text reading periods later in the day. Evaluation criteria are found on the next page of this Guide. A "second attempt" evaluation and criteria follow.

COORDINATOR'S KEY

EVALUATION #1

Below are the three statements of negative assumptions we have been discussing. Following those are two statements which might be made by guidance personnel. Participant questions follow, with answers and/or types of appropriate responses. At least six of the eight questions must be answered correctly/acceptably for the participant to achieve this objective. Each question must

a) have the correct number;
b) make reference to each fact presented in this key;
c) have at least the portion shown in this key underlined; and
d) be rated as acceptable by you according to the criteria in this key.

You should read the correct answers for Part a of each question as soon as all evaluations have been collected.

Negative Assumptions

1. All mental, emotional, and learning problems exhibited by a student with a physical disability are directly related to her/his disability.

2. The same sequence of course work, the same kinds of career plans, and the same limitations on life management and leisure goals are appropriate for all students possessing a similar type and degree of physical disability.

3. Students with physical disabilities, especially those with great involvement, have no needs other than those directly related to their disabilities.

Statements for Evaluation, Objective 1

1. A guidance staff person says to a student with a moderate cerebral palsy condition, "Linda, Mrs. Anderson is delighted with your work in geometry. I've got you in an advanced algebra course for next semester. Of course, we'll waive the course in cooking and home management; I doubt that you could get around or manage equipment in there very well, and anyway, you won't need it since you'll no doubt always be living at home."

a. Which assumption above is most closely reflected by this statement?

#2

b. What are the facts expressed in this statement?

Linda's doing well in math and is scheduled for advanced algebra.

c. What part(s) of the statement express(es) the negative assumption? (Underline the words of the statement. Underline whole phrases or sentences.)

"Of course we'll waive the course in cooking and home management; I doubt that you could get around or manage equipment in there very well, and anyway, you won't need it since you'll no doubt always be living at home."

d. How could you revise the statement so it reflects the facts, but not the assumption?

This statement should include the facts, but not reflect the assumption. An example is, "Linda, Mrs. Anderson is delighted with your work in geometry. We've got you in an advanced algebra course for next semester. Have you thought about ever living away from home? The course in cooking and home management would be very valuable for you if you ever decide to move out on your own."

2. A guidance staff member says to a guidance intern, "Brian's deaf, can't hear anything at all. He's got emotional problems too--doesn't get along with teachers or the other kids very well. No doubt the two situations are related."

a. Which assumption above is most closely reflected by this statement?

#1

b. What are the facts expressed in this statement?

Brian is deaf; he also has emotional problems.

c. What part(s) of the statement express(es) the negative assumption? (Underline the words of the statement. Underline whole phrases or sentences.)

"No doubt the two situations are related."

d. How could you revise the statement so it reflects the facts, but not the assumption?

This statement should include the facts, but not reflect the assumption. An example is, "Brian's deaf, can't hear anything at all. He's got emotional problems too--doesn't get along with teachers or the other kids very well. Perhaps the deafness is part of the root of his emotional problem."

If Objective 1 is not achieved:

Ask the participant to reread the text and consult you about areas of difficulty in answering questions. Then have the participant answer the questions on the following page. Three out of the four answers must be correct/acceptable for the participant to achieve the objective. The answer key follows the questions.

Name _____

EVALUATION #1

(Second Attempt)

Below are the three statements of negative assumptions. One example statement follows them. You are to answer the questions following the statement. Three of the four responses must be correct/acceptable for you to achieve the objective.

1. All mental, emotional, and learning problems exhibited by a student with a physical disability are directly related to her/his disability.

2. The same sequence of course work, the same kinds of career plans, and the same limitations on life management and leisure goals are appropriate for all students possessing a similar type and degree of physical disability.

3. Students with physical disabilities, especially those with great involvement, have no needs other than those directly related to their disabilities.

A counselor says to a parent, "Andy's got a great attitude; polio sure hasn't defeated him. I'm sure he's got a good future in a suitable job. An office job of some kind would seem best, since getting around is such a time-consuming project for him."

a. Which assumption above is most closely reflected by this statement?

b. What are the <u>facts</u> expressed in this statement?

c. What part(s) of the statement express(es) the negative assumption? (Underline the words of the statement. Underline whole phrases or sentences.)

d. How could you revise the statement so it reflects the facts, but not the assumption?

COORDINATOR'S KEY

EVALUATION #1

(Second Attempt)

"Andy's got a great attitude; polio sure hasn't defeated him. I'm sure he's got a good future in a suitable job. An office job of some kind would seem best, since getting around is such a time-consuming project for him.

a. Which assumption above is most closely reflected by this statement?

   #2

b. What are the <u>facts</u> expressed in this statement?

   Andy hasn't been defeated by his polio; it takes time for him to get places.

c. What part(s) of the statement express(es) the negative assumption? (Underline the words of the statement. Underline whole phrases or sentences.)

   "An office job of some kind would seem best"

d. How could you revise the statement so it reflects the facts, but not the assumption?

   This statement should include the facts, but not reflect the assumption. An example is, "Andy's got a great attitude; polio sure hasn't defeated him. I'm sure he's got a good future in a suitable job. It does take him time to get around, so we'd have to check into methods of transportation if he got a job where he had to travel."

OBJECTIVE 2

5' Text or Lecture

Ask the participants to read the text of their modules for Objective 2. During this period you may begin evaluating the statements for Objective 1.

10' Slides/Self-Assessment *(Activity 2)*

When all participants have finished reading, talk to them briefly on the topic of personal feelings about disability. The following paragraphs give an example of the type of presentation you should give at this time. Feel free to amplify and stress points you think are important.

"We've been concentrating on exposing assumptions about people with disabilities, assumptions which cause guidance people to see them, and work with them, as 'problem people' instead of 'people with problems.' Now we'd like to focus on even more basic issues: how do you feel personally about physical disabilities? Not only do your personal feelings affect your assumptions--that is, your mental constructs--about people with disabilities, they also affect the quality of your moment-to-moment interactions in many subtle ways.

"Later we will practice some specific behaviors in dealing effectively with people with disabilities. At this point we are concerned with the feeling basis of these behaviors. If you feel okay about physical exceptionality, then the skills are easier to acquire and use than if you don't feel that way. So our next activity is designed to help you become more aware of your feelings about various disabilities."

You have two options for the self-assessment:

1. ask participants to begin with question one, which requires you to show two slides of people with various disabilities, and then have them complete questions two through eleven; or
2. ask participants to begin with question two and continue on through question eleven, in which case no slides are used.

It is strongly recommended that slides be used if at all possible, as the impact of the activity can be greatly increased.

If you are not planning to use slides of people with disabilities, have participants turn to page 27 in their modules and begin the written self-assessment.

If you are planning to use slides, ask participants to turn to page 26 in their modules and read over the questions before you begin the slides. Ask participants to rate their reactions as you show the slides. When the slides have been shown, have participants continue through the written self-assessment.

In order for participants to achieve the objective, you must see their self-assessments to be sure every assigned question was answered. You may wish to review the self-assessments during a coffee break after the following discussion.

15' Discussion

When everyone has completed the self-assessment, ask for reactions and experiences relative to any particular question or slide. In addition to these reactions, answers to one or more of the following questions may provide bases for discussion:

1. Has any participant experienced a situation with someone who has a physical impairment that caused anxiety, revulsion, or fear in the participant?
2. How was the situation handled?
3. Was the anxiety, revulsion, or fear lessened by the end of the encounter?
4. Can you identify some factors that facilitated this change?
5. What kinds of positive feelings did you come away with about the person with the disability, if any?
6. Do you feel some people should not offer guidance services to those with physical disabilities?

Though this section of the module asks only that participants become *aware* of their attitudes toward particular disabilities, remember that this discussion may be beneficial in helping these attitudes *change*, as participants discuss their common reactions and their own positive experiences with people with disabilities. The discussion may provide some of the most open and valuable insights of the day, so feel free to let it go over 15 minutes.

OBJECTIVE 3

15' Text

Ask participants to read the text of their modules for Objective 3. During this period you may continue evaluating the statements for Objective 1 if necessary.

20' Discussion

When all participants have finished reading, ask the group to state the five basic stages of the model and list these on the board. Then ask participants to turn to page 38 in their modules where they will find a list of six statements which students might make. These statements are found on the next page of this Guide, together with questions for discussion. Read each statement or select those you prefer. Participants are to classify each statement. Volunteer participants should then suggest what approaches a guidance staff member might take in response to each and explain why they chose those approaches. Encourage them to use their own knowledge or experience in stating what reactions would be most effective. Encourage a variety of responses, as this will help participants learn from one another. Ask each person to explain why she/he prefers that approach. Correct answers and feedback suggestions are given.

ACTIVITY #3: EXAMPLE STUDENT BEHAVIORS

1. Bruce, 16, has cerebral palsy of the athetoid type. He is a quadriplegic with moderate involvement, is able to walk alone, and has above-average intelligence. In a career guidance class he has missed several assignments on seeking information from local employers. He says, "I don't want to call them. I just don't know what I want to do. I don't even know what to ask."

   a. Which stage does this statement express?

      Uncertainty

   b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

   c. (Ask for other response approaches and rationales.)

2. Ken is a 17-year-old who has lost his leg at the knee in a motorcycle accident. Two days after the accident he says, "I gotta be out of the hospital in two weeks for the start of baseball practice!"

   a. Which stage does this statement express?

      Shock

   b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

   c. (Ask for other response approaches and rationales.)

3. Carlos, 8, has been blind from birth and never encouraged by his parents to be independent. He is very passive. One day while talking to his counselor he says, "I lost my social studies assignment on the way to school this morning. Last night I lost a record--it broke." Later he says, "My dog got lost a couple of weeks ago."

   a. Which stage does this statement express?

      Sadness

   b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

   c. (Ask for other response approaches and rationales.)

4. Terry is 15 and has sickle cell disease. She has been hospitalized several times for sudden onset anemia and other complications, and though she once participated in several active sports, her physical activities are now limited. She has been uncooperative and quarrelsome with her teachers and friends. To one teacher, a former favorite, she says, "You just want to make me good at books so I'll fit better in your nice white world."

a. Which stage does this statement express?

Anger, misdirected at the teacher

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

c. (Ask for other response approaches and rationales.)

5. Rebecca, 17, has epilepsy, fairly well controlled, but occasionally she has grand mal seizures. Talking to the career center specialist, she says, "I'd like to go into medicine, but I'm afraid I'd upset patients or not be able to use equipment and stuff well enough. Maybe in some specialties that wouldn't matter though."

a. Which stage does this statement express?

Acknowledgement; willingness to explore the real possiblities.

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

c. (Ask for other response approaches and rationales.)

6. Ben, 12, has muscular dystrophy and is no longer able to attend school. He refuses to see the itinerant teacher and insists, "There's no use in my learning anything. I'm just going to die, get weaker and weaker until I'm dead. Don't even let that teacher in the front door."

a. Which stage does this statement express?

Anger. The response is depressed and despairing, common signs of unexpressed anger.

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

c. (Ask for other response approaches and rationales.)

15' Evaluation

The evaluation is a written one and is found in the module. A statement is to be classified and a reaction suggested as in the activity. You will need to collect and evaluate these during text reading periods later in the day. Evaluation criteria are found on the next page of this Guide, and a "second attempt" evaluation and criteria follow. Be sure to erase the list of stages from the board before the evaluation begins.

COORDINATOR'S KEY

EVALUATION #3

A. List the five basic stages of the model of adjustment described in the module text.

1 - Shock

2 - Sadness

3 - Anger

4 - Vulnerability or uncertainty

5 - Acknowledgment

B. Below are three descriptions of behavior guidance personnel might encounter in students with disabilities. You are to answer the questions under one of these descriptions, whichever you choose.

1. Ann is 15, congenitally blind, and shows little desire to succeed at anything. When encouraged to try anything new, her response is, "I don't want to. It's too much trouble," and an expressionless stare.

a. What stage does this statement best reflect?

Anger (unexpressed and revealed as apathy)

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate.

The responses here may vary greatly. The essential criterion for acceptability is that the response and/or the rationale show a relationship to the stage named in (a). If the stage is incorrect, this response is still acceptable if it relates appropriately to the incorrect stage.

2. Chin, 10, has been profoundly deaf since birth and his speech is difficult to understand. He does not want to enter a regular classroom for any subject, though he lipreads well. He says, "The work will be too hard for me. I don't know the teacher--I'll bet she's hard. I'll bet she's the hardest teacher in the school."

a. What stage does this statement best reflect?

Uncertainty or vulnerability

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate.

The responses here may vary greatly. The essential criterion for acceptability is that the response and/or the rationale show a relationship to the stage named in (a). If the stage is incorrect, this response is still acceptable if it relates appropriately to the incorrect stage.

3. Lois, 12, has recently had polio and is paralyzed from the waist down. She is not expected to walk again. She insists, "I can walk. I know I can walk. I know I can stand as straight as anyone. All it takes is to try hard enough."

a. What stage does this statement best reflect?

Sadness (unexpressed and revealed as denial)

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate.

The responses here may vary greatly. The essential criterion for acceptability is that the response and/or the rationale show a relationship to the stage named in (a). If the stage is incorrect, this response is still acceptable if it relates appropriately to the incorrect stage.

If Objective 3 is not achieved:

Ask the participant to reread the text and consult you about areas of difficulty in answering questions. Then have the participant answer the questions on the following page. For A, four of the five stages must be named correctly; for B both responses must be correct or acceptable. The answer key for these questions follows them.

Name _____

EVALUATION #3

(Second Attempt)

You are to answer each of the following questions. For A, four of the five stages must be named correctly; for B, both responses must be correct or acceptable for you to achieve the objective.

A. List the five basic stages of the model of adjustment described in the module text.

B. Answer the questions under the following description.

1. Jim is 12 and has recently been in an accident which left large scars on half his face. His grades, previously high, have fallen badly in recent weeks; his great interest in science projects seems to have vanished. When questioned about these changes, he answers, "I just don't want to do that stuff any more."

a. What stage does this behavior best reflect?

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

COORDINATOR'S KEY

EVALUATION #3

(Second Attempt)

A. List the five basic stages of the model of adjustment described in the module text.

1 - Shock

2 - Sadness

3 - Anger

4 - Uncertainty or vulnerability

5 - Acknowledgement

B. Answer the questions under the following description.

1. Jim is 12 and has recently been in an accident which left large scars on half his face. His grades, previously high, have fallen badly in recent weeks; his great interest in science projects seems to have vanished. When questioned about these changes, he answers, "I just don't want to do that stuff any more."

a. What stage does this behavior best reflect?

Anger

b. Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.

The responses here may vary greatly. The essential criterion for acceptability is that the response and/or the rationale show a relationship to the stage named in (a). If the stage is incorrect, this response is still acceptable if it relates appropriately to the incorrect stage.

OBJECTIVE 4

15' Text

Ask participants to read their modules for Objective 4. During this period you may begin evaluating the statements for Objective 3.

45' Presentation/discussion

For Activity #4, use the activity description on the next three pages to present to a volunteer or to the whole group situations showing difficulties which people with disabilities may face. Feel free to elaborate or dramatize these situations based on your own experience. You may want to point out to the group that every one of the incidents described is based on an actual event. Encourage participants to contribute their experience in identifying obstacles and solutions to both physical and social difficulties. Remember that their success in the evaluation may depend on your covering all necessary points during this discussion, so be sure you've read the Evaluation first to know what is expected.

COORDINATOR'S GUIDE

ACTIVITY #4

This activity is designed to help participants perceive their own surroundings from the point of view of a person with a disability. Ask for a volunteer from the group, who may remain seated. Now ask the person to visualize a series of events similar to the following. Add details if you like, and make your description as realistic as possible:

"Imagine yourself out doing last-minute Christmas shopping on Christmas Eve, rushed and harried. You have one more gift to buy at a store across the street, and you dash into the street to go there. You hear a screech of brakes and whirl around to see a car only inches from you . . .

"Your next conscious moment is when you awaken in a hospital. Bars and tubes are all around, and a nurse is standing over you. You whisper, 'Where am I?' and she says, 'Just a minute, I'll be right back,' and disappears. She comes back soon with a doctor, and you ask her the same question. She says, 'You've been in an accident. You were hit by a car. You're going to make it okay, but you were hurt pretty bad.' She stops for a minute. Then she says, 'There was damage to your spinal cord. We don't believe you'll be able to use your legs or your right arm any more.'

"You're in the hospital for about eight weeks, during which it's confirmed that lifetime paralysis of your affected limbs is virtually certain. You find you cannot use your legs at all, that you can move and rotate your right shoulder to a limit of about 10° from your body but cannot use your fingers. You watch the muscles of these limbs shrink to two-thirds of their former size. You acquire a motorized wheelchair but don't navigate it too well when the time comes to leave the hospital. You are brought home and taken to your front door by ambulance attendants--home to 'resume your life.'

"I want you to consider an ordinary day in your life and to describe your activities in as much detail as possible, beginning with getting out of bed in the morning. Imagine you are disabled as I described, and tell us every change you can think of that would occur in your activities. Tell us about every difficulty you can foresee. I'd like you to use only the pronoun 'I' and to be very specific."

Let the participant respond, but try to keep him/her to details, e.g., "But how would you go about eating breakfast?" If necessary, ask the participant to physically show you what would have to be done. Remind the participant to use only 'I,' not 'you,' in describing situations, thereby forcing her/him to remain in a concrete situation.

After five to ten minutes, stop the participant at a comfortable place, thank him/her, and continue as follows:

"Now I'd like each of you to visualize yourself after such an accident. Think about each of the following situations; if you'd like to respond, please do. Imagine your family or those you live with being confronted with this situation. What might their reactions be when you arrived home? After three days? A week? A month? What practical frustrations might they face? Would they communicate openly with you or bottle up their feelings? What feelings do you think they might have when looking at your non-functioning limbs? Upon having to change their image of your physical abilities? Upon bringing friends home?

"Consider your own friends and co-workers. How might they react to you? How might your functioning in your job be limited? How might your clients or students react? What types of reactions can you foresee?"

There are several types of common negative family/friend reactions to those with disabilities (many of which were mentioned in the text for Objective 3) which can probably be identified in participant contributions to this discussion, and it is important that you identify them, as this knowledge will be needed for the Evaluation for this objective. These include:

1. Frustration, often displayed as anger at the special difficulties caused by a disability
2. Overprotection or oversolicitousness
3. Demands for unattainable achievement
4. Embarrassment and nervousness

As an example of each of these types occurs, you will need to identify it and *write it on the board* to help participants fix the type firmly in their minds. If other types of reactions come up, feel free to add these to the list too. If no examples come up to illustrate a particular type of family/friend reaction, use an example like the following. Be sure each of the four types is illustrated either in discussion or by an example similar

to one below. Use them *in addition to* examples from the discussion as well, if you feel this is desirable.

1. Frustration: You awaken in the middle of the night needing to use the bathroom. You have to wake your spouse to help you, who says, "Damn it! A job and all the housework and all the responsibility for the kids and now *you* to lean on me too! Don't you know I need some sleep?"

2. Overprotection: A close friend comes to visit and insists on doing everything for you, not letting you move to get anything and even insisting on helping you eat. You overhear her say, "Poor thing, he'll need total care for the rest of his life, won't he?"

3. Demands: Your 11-year-old son says, "Aw Dad, if you can't catch the ball for me, the least you could do is try to throw it right!"

4. Embarrassment: On your first day back in the guidance office several of your colleagues say hello and then don't seem to be able to find any other words.

Another part of the evaluation asks participants to suggest strategies for solving mobility and social problems. These will no doubt arise during the discussion and you should encourage them, classifying each within one of the two categories of approach:

a. helping the person directly, or

b. trying to positively influence the person's environment.

You may wish to put these headings on the board, as you will also use them later in discussing strategies for solving problems with strangers.

When all types of family/friend reactions have been illustrated and discussed, resume the presentation as follows:

"Now I'd like each of you to consider your reactions to the following situations and share them if you'd like.

"1. You are sitting with a group of non-disabled colleagues you haven't met before, waiting for a meeting to begin. When you try to enter the conversation, people avoid responding to what you say and basically ignore you.

"2. You're in the kitchen when a new neighbor comes in to be introduced. Upon seeing you, he grows so flustered that he nearly stammers his greeting and leaves without another word.

"3. You are crossing at a busy street corner. You move a little slowly in the motorized chair, but manage quite well. A man comes up

beside you, says, 'Here, I'll help you,' and takes over the direction and operation of your chair, pushing you beyond where you're headed.

"4. You are introduced to a woman at a party. You say, 'Hello,' and she says, 'Oh, you poor thing!'

"5. You are eating out in a restaurant. A group of diners is leaving and one woman pauses by your table and says, 'Why don't you stay at home where you should be, instead of making us look at you during our dinner?'

"6. You are shopping in a store. When you ask a clerk for help in selecting a shirt, she responds as if you aren't quite bright, asking you if you're sure of the size, if that's the right color for you, if you have enough money, and so forth. Another clerk asks her a question and she answers, 'Yeah, I'll be there as soon as I get through with this cripple.' As you start to leave, she says, 'Bye now,' and pats you on the head.

These are common types of reactions people with disabilities encounter. The examples I gave represent the following general reaction types."

1. Ignoring or avoiding
2. Embarrassment or nervousness
3. Assuming that a disabled person is incompetent to do or decide anything for her/himself
4. Pity
5. Revulsion
6. Assuming that a physically disabled person is also mentally disabled.

Again, be sure to encourage participants to suggest strategies for alleviating problems, classifying them into the two approaches described earlier.

20' Evaluation

When the discussion reaches a comfortable stopping point, have participants go on to the Evaluation. Remember to erase the types of reactions and solutions from the board before the evaluation begins.

The evaluation for Objective 4 is a written one and is found in the module.

Participants must list physical/architectural obstacles and describe strategies for lessening a difficult social situation. Two strategies should be indicated, one for helping the student and the other for positively influencing the student's environment. Both parts of Objective 4 are achieved by your judgment of the participants' responses as acceptable. Criteria for acceptability are indicated on the Coordinator's Key that follows. For part A, four of five responses must be acceptable; for part B, two of the three statements must be acceptable for the participant to achieve this objective. Suggestions for a "second attempt" at achieving Objective 4 follow the Coordinator's Key.

COORDINATOR'S KEY

EVALUATION #4

A. *The participant must list at least five physical or architectural obstacles people with physical disabilities may encounter, the disabling conditions each would affect, and why that obstacle would affect that condition (if this is not obvious). These may be from the text, subsequent discussion, or the participant's own experience. These must simply be genuinely problematic objects or structures in your judgement. If you have doubts, discuss them with the participant.*

B. 1. *Either 1, 2, or 3 should be entered.*

2. *If 1 is entered above, this answer should be "frustration and anger" or similar words.*

If 2 is entered above, this answer should be "ridicule" or similar words.

If 3 is entered above, this answer should be "revulsion" or similar words.

3a. *This strategy description should relate to the incident selected in B1; it should approach the problem from the point of view of helping Ellen directly; it should specify the what, who, when, where, and how of the strategy, as well as establishing logical continuity of steps.*

b. *This strategy description should relate to the incident selected in B1; it should approach the problem from the point of view of trying to positively influence the student's environment; it should specify the what, who, when, where, and how of the strategy, including establishing logical continuity of steps.*

If Objective 4 is not achieved:

Ask the participant to reread the text and consult you about areas of difficulty in answering questions. Then have the participant talk with you about why you judged her/his answers unacceptable or incomplete. If the participant can explain or supplement his/her answers to your satisfaction, the objective has been achieved.

OBJECTIVE 5

10' Text

Ask the participants to read the text of their modules for Objective 5. During this period you may begin evaluating the responses for Objective 4.

20' Model role-play/discussion

On the next pages is the script of a model role-play demonstrating the use of particular skills in open communication about a disabling condition. This is designed to be acted out by you (the coordinator) and a volunteer participant; or if you prefer, a tape-cassette version may be employed instead. If you choose to act out the script, be sure to make a copy for the participant.

Before beginning the role-play, have the participants turn to page 53 in their modules. Listed there are nine skills which are important in open communication about a disability and are exemplified in the role-play. A list of the nine skills follows the script for your use. Ask participants to try to identify each skill in practice during the role-play.

At the conclusion of the role-play lead participants in analysis and discussion of the skills. In discussing each skill, use the similarly numbered sentences from the role-play as an example. Remember that the role-play has a specific and limited function: the development of skills in open communication about a disability, not the illustration of general counseling techniques.

Points to note are these:

1. The first five skills are simple, first-order behaviors, while the last four are more complex skills and cover a variety of possible combinations of simple behaviors, depending on the disability and the situation.

2. The use of a particular skill is not always appropriate with a particular student (especially 5 and 9), but counseling staff need to be <u>able</u> to display each in some circumstances.

3. Advise participants that they will need to perform the skills during their own role-plays. They may use an Evaluation Checklist as prompting at that time, but they should be very familiar with the skills so as not to interrupt or slow their role-play excessively. Advise them that the observer must note the presence of five of the nine skills for them to achieve the objective.

4. Ask for questions or comments. The more discussion there is, the more familiar they will be with the skills.

MODEL ROLE-PLAY SCRIPT

G = Guidance staff member: Mr/Ms. Renner, Joanne's counselor.

S = Student: Joanne, 13 years old and in the eighth grade; partially paralyzed on the left side, she uses a cane for walking.

G: Hi, Joanne.

S: Hi, Mr. Renner. Are you busy?

G: Not really. What can I do for you?

S: I just want to talk.

G: Sure. Stay there, I'll put the chair next to you.

S: Thanks. *(sits slowly)*

G: Is there some problem?

S: Yeah.

G: Can you tell me about it?

S: Well--I'm supposed to be going to my English class right now--but I just couldn't make myself go. *(drops face into hand, perhaps crying)*

G: *(Touches her left arm or shoulder briefly)* It seems to bother you a lot to have to go to that class.

S: It's not just that class. It's all my classes.

G: All your classes?

S: Yeah. *(pause)* Even coming to school is just so hard I can hardly stand it.

G: Do you have any idea why?

S: Well--I just hate having anybody look at me. *(silence)*

G: You hate people looking at you.

S: Yeah. I just feel I must be so--awful to look at. I walk into the room and I feel like everybody's thinking, 'Ugh, there's Joanne. How ugly.'

G: Do you feel like people think you're ugly because of your paralysis?

S: Yeah. *(pause)* And I especially hate boys to look at me.

G: Being partly paralyzed means boys won't think you're an attractive girl, is that it?

S: Um-hm--*(drops her head again and doesn't move)*

G: You know, Joanne, I don't know a lot about your paralysis. Tell me how it occurred.

S: When I was little, a car hit me in the street, and the doctors said my muscles were injured permanently.

G: I see. And how much can you use your arm? *(lifts her arm)*

S: I can move my shoulder a little, but I can't use my hand.

G: How about your leg? Can you walk without the cane?

S: Yeah, but I fall easy without it.

G: You know, when I see you walk around campus I really don't notice that you walk much differently than others.

S: No, I don't limp much.

G: And even though you can't move your arm much, it's shaped pretty normally. Your hand is too; in fact, both your hands are pretty. Are there many things you can't do on account of your paralysis?

S: Well, lots of sports are out--but I play softball. I can pitch O.K., and bat with my right, just bracing it with my left. Then someone else runs for me.

G: How do you feel about that? You're not embarrassed playing ball?

S: No, I guess not. I've always done it.

G: Do boys ever play with you?

S: Sometimes after school. Usually they watch instead of play.

G: Does it bother you to have them watch?

S: Not really. I never think of it.

G: It sounds like there are some things you can't do, but lots of things you can. It also sounds like there are some situations where you hate the fact that you're paralyzed and others where it doesn't bother you much. Sometimes it's even an advantage: the glory of hitting a base hit without all the hard work of running it!

S: *(Smiles)* Yeah.

SKILLS IN OPEN COMMUNICATION ABOUT A DISABILITY

1. Using terms descriptive of the condition without hesitation or stumbling

2. Looking straight into the eyes of the student with the disability

3. Touching the student comfortably and without hesitation when appropriate

4. Looking straight at the disabled parts of the student's body, if these are apparent

5. Touching the disabled parts of the body, if appropriate (Caution: sensitivity to the student's readiness to have the disabled part touched is important.)

6. Questioning the student without hesitation or embarrassment concerning the full extent of her/his limitations and difficulties related to the disability

7. Focusing on the student's strengths, while at the same time acknowledging his/her limitations

8. Helping the student compensate for lacks in functioning or communicating, frankly and without excessive solicitousness (i.e., guiding a blind boy past an obstacle, telling a speech-impaired student you don't understand her and would like her to repeat more slowly what she said, etc.)

9. Using humor appropriately (Caution: great care and tact are needed in sensing what kinds of humor are appropriate and what kinds may be offensive. When in doubt, leave it out!)

100' Role-plays/evaluation

Now ask participants to divide into groups of three, with some groups of four as necessary. On the next pages you will find descriptions of four roles for students with a disability and one role of a guidance staff member. Each group should be given a different student role for each group member and one description of the guidance staff member role, along with one (or two for groups with four members) observer checklist for each student role. Observer checklists may be found on pages of the participant's materials. Be sure you have made enough copies before reaching this objective. Copies should be printed on one side only.

Two members of each group should perform the first role-play, with the observer(s) using the checklist(s) to help them evaluate the role-play and offer feedback afterwards. Role-plays are the evaluation for Objective 5. The observer rates the performance of the "guidance staff member" *only* (not the "student") on the basis of the number of specific skills exhibited (five are required for achievement of the objective), and offers feedback on specific points. For the second role-play, group members should exchange roles. They exchange again for the third (and fourth) role-plays, so that no member plays a student or guidance staff member more than once. During the role-plays you may continue evaluating the responses for previous objectives. Try to finish quickly so you can observe the role-plays and offer some comments of your own if you wish. After the group regathers, collect the "Rating" portion of the "Evaluation Checklist" for each "guidance staff member" to be sure each achieved the objective.

If the objective is not achieved:

Ask the participant and the one who observed him/her to discuss the role-play with you, especially the skills that were not demonstrated. If you feel another role-play should be done, select a different "student" role and ask the observer to play the "student" while you act as observer. If the participant seems to be having great difficulty practicing the skills while "acting," you may have her/him read the script of the model role-play and use the skills where appropriate. At your option, this can constitute achievement of the objective.

EVALUATION #5

ROLE OF "GUIDANCE STAFF MEMBER"

You are a guidance staff member; assume your specific role is the same as your actual role in your setting, and tell your "student" partner what that role is. If you are not now operating in a guidance setting, choose a role you would like to practice: counselor, career center specialist, peer counselor, etc. You are to respond to the student problem before you, keeping in mind the skills on the "Evaluation Checklist" in discussing the disability openly. You are to demonstrate each of these skills to the best of your ability during the interaction. This role-play should occupy three to seven minutes. The observers will provide feedback for discussion when the role-play is completed.

(1) Role of "Student"

You are a seventh grade student who is moderately deaf and who lip reads adequately. You have been attending your junior high for a couple of months now. Your parents have always been very protective and are worried about your going to a new school. You are adjusting pretty well and wish they'd stop bugging you, but you don't know how to handle them and have come to the guidance center to talk about the problem.

If you would like, take a couple of minutes to think about some specific situations or interactions which have made you come to the guidance center, but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role-play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have gotten into in your role and to feel and project the emotions you might have genuinely experienced in these situations. The role-play should occupy three to seven minutes. The observers will provide feedback for discussion when the role-play is completed.

(2) Role of "Student"

You are a tenth grade student, who is dwarfed and lamed in your left leg due to an accident in infancy. You have just transferred to a new high school. You haven't had much contact with other young people in the past. Most other students avoid you and you are lonely. You are talking to this guidance staff person because you don't know how to handle this loneliness.

If you would like, take a couple of minutes to think about some specific situations or interactions which have made you come to the guidance center, but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role-play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have genuinely experienced in these situations. The role-play should occupy three to seven minutes. The observers will provide feedback for discussion when the role-play is completed.

(3) Role of "Student"

You are a twelfth grade student with epilepsy who has occasional grand mal seizures. Your biology teacher seems to be very afraid of your condition and has excluded you from several class activities: field trips, experiments requiring use of equipment, and class presentations. Your seizures are not fully controlled but are rare, and they can be dealt with by anyone willing to protect your head or limbs from damage. You are afraid to talk to the teacher but have come to the guidance center.

If you would like, take a couple of minutes to think about some specific situations or interactions which have made you come to the guidance center, but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role-play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have gotten into in your role and to feel and project the emotions you might have genuinely experienced in these situations. The role-play should occupy three to seven minutes. The observers will provide feedback for discussion when the role-play is completed.

(4) Role of "Student"

You are a fourth grade student with cerebral palsy. You have moderate spasticity, cannot stand straight, and move with stiff and jerky motions. You are just beginning to attend public school. You have had a supportive and open home atmosphere and started school with confidence, but the taunts of a group of older children have frightened and humiliated you. The teacher has sent you to the guidance center.

If you would like, take a couple of minutes to think about some specific situations or interactions which have made you come to the guidance center, but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role-play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have gotten into in your role and to feel and project the emotions you might have genuinely experienced in these situations. The role-play should occupy three to seven minutes. The observers will provide feedback for discussion when the role-play is completed.

WRAP-UP

During the wrap-up, you should try to bring a feeling of closure to the workshop. Respond to any unanswered questions, direct participants to any further resources you are aware of (including those in the module bibliography/ resource list), and if they desire, let them discuss the workshop content and activities. You might mention the workshop's goal once again and help them focus their day's activities in light of it.

On the next five pages are two sample instruments, the Module Performance Record and the Evaluation Questionnaire for Staff Development Workshops. You may wish to use these instruments to gather information for evaluating any workshop in which you administer this module, and for making decisions about future workshops. The Module Performance Record (MPR) is a form for tallying participants' achievement of objectives. The Evaluation Questionnaire seeks participants' opinions on four dimensions: (1) perceived value of the workshop; (2) effects of participating in the workshop; (3) role and performance of the coordinator; and (4) recommended improvements in the workshop. As it now stands, the questionnaire should take participants 10-20 minutes to complete. You, as module coordinator, should complete the MPR form based upon the results of the postassessment or other evidence supplied by participants. If you duplicate the Evaluation Questionnaire for participants to complete, we suggest you print it as a four page booklet.

NATIONAL CONSORTIUM ON COMPETENCY-BASED STAFF DEVELOPMENT

MODULE PERFORMANCE RECORD

MODULE TITLE: _____

WORKSHOP DATES: _____

WORKSHOP COORDINATOR(S): _____

_____

Participants' Names (Alphabetically)	OBJECTIVES (Place a check (✓) mark for each objective achieved.)						
	1	2	3	4	5	6	7
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Developed at the American Institutes for Research, under support by the United States Office of Education, Department of Health, Education, and Welfare.

NATIONAL CONSORTIUM ON COMPETENCY-BASED STAFF DEVELOPMENT

EVALUATION QUESTIONNAIRE FOR STAFF DEVELOPMENT WORKSHOPS

Your responses to the brief questions in this booklet will help us evaluate the workshop you just completed and make decisions regarding future workshops. Please take 10-20 minutes to answer honestly and thoughtfully. You need not sign your name, but we do need your help. Please answer each question. Thank you.

Name (Optional) _____ Date _____

Module Title _____

A. General Issues Related to the Workshop

Respond by checking the column (A, B, C, D, or E) of the statement which best expresses your feeling or opinion on each item in the following list. If none of the possible choices precisely represents your view, pick the one that comes closest.

STATEMENTS	Column A I strongly agree	Column B I agree	Column C I disagree	Column D I strongly disagree	Column E I don't know. I have no basis for answering.
1. This workshop made a valuable contribution to my professional development.					
2. I acquired no new knowledge during this workshop.					
3. I would not recommend this workshop to anyone else.					
4. I am glad I attended this workshop.					
5. In this workshop, I experienced at least one positive change in my knowledge, attitudes, or skills.					
6. As a result of this workshop, I expect that I will help improve the career guidance program in my work setting.					
7. I experienced at least one negative effect from this workshop.					
8. This module must be improved.					
9. The Coordinator was an asset to this workshop.					
10. The Coordinator was unprepared.					
11. The Coordinator was poorly organized.					
12. The Coordinator was clear and to the point.					
13. The material and activities in this workshop were not painful.					
14. The material and activities were applicable to my needs.					
15. The material and activities were routine and boring.					
16. The workshop's objectives addressed the training needs that I hoped they would.					

Developed by the National Consortium on Competency-Based Staff Development in cooperation with the American Institutes for Research, under support by the United States Office of Education, Department of Health, Education, and Welfare under Part C of the Vocational Education Act of 1963.

B. Please list and briefly describe up to three major positive changes that you have experienced in your knowledge, attitudes, or skills because of this workshop. Continue on the back of this booklet if necessary. If you did not experience any positive changes, please check the appropriate space.

_____ There were no positive changes.

C. Please list and briefly describe any negative effects you have experienced because of this workshop. Continue on the back of this booklet if necessary. If you did not experience any negative effects, please check the appropriate space.

_____ There were no negative effects.

D. Please list and briefly describe any improvements you anticipate in your career guidance program as a result of this workshop. Continue on the back of this booklet if necessary. If you don't expect any improvements as a result of this workshop, please check the appropriate space.

_____ I don't expect any improvements in my career guidance program as a result of this workshop.

E. Please list and briefly describe any other comments on this workshop, criticisms of it, or suggestions you have for improving it. We are especially interested in your ideas on topics or activities that should receive more or less emphasis. Continue on the back of this page if necessary.

NATIONAL CONSORTIUM COMPETENCY-BASED STAFF DEVELOPMENT RESOURCES

Modules 1-12 comprise a series on Developing Comprehensive Career Guidance Programs.

1. Career Development Theory
   Barbara Sanderson and Carolyn Helliwell

2. Program Development Model
   Charles Dayton and H. B. Gelatt

3. Assessing Desired Outcomes
   Charles Dayton

4. Assessing Current Status
   Phyllis DuBois

5. Establishing Program Goals
   Charles Dayton

6. Specifying Student Performance Objectives
   Laurie Harrison

7. Selecting Alternative Program Strategies
   H. B. Gelatt

8. Specifying Process Objectives
   Barbara Pletcher

9. Developing Program Staff
   Barbara Pletcher

10. Trying Out Activities and Monitoring Early Implementation Efforts
    Steven M. Jung

11. Conducting Summative Evaluation (Cost-Impact Studies)
    Jean Wolman

12. Communicating Evaluation Results
    Sarah Roberts

The remaining modules address other competencies necessary for providing comprehensive career guidance.

13. Utilizing Strategies for Adult Guidance
    Zandy Leibowitz and Nancy Schlossberg

14. Designing Programs for Adult Guidance
    Zandy Leibowitz and Nancy Schlossberg

15. Providing Life/Career Planning for Women and Girls
    Janice M. Birk

16. Providing Career Guidance for Young Women
    Pamela G. Colby

17. Enhancing Understanding of Students with Physical Disabilities
Susan L. McBain

18. Helping Students Explore Work and Leisure Options
Pamela G. Colby

19. Planning a Career Resource Center
Robert A. Wood, Neal Rogers, and Clella Klinge

20. Developing People Relationship Competencies for Career Resource Center Technicians
Jill Paddick and Dale Dobson

21. Developing Facility Maintenance Competencies for Career Resource Center Technicians
Clarence Johnson

22. Planning Pre-Employment Programs
Joyce Fielding and Marvin Fielding

23. Conducting Job Development Programs
Joyce Fielding and Marvin Fielding

24. Conducting Job Placement Programs
Joyce Fielding and Marvin Fielding

25. Conducting Follow-Up and Follow-Through Programs
Joyce Fielding and Marvin Fielding

26. Imaging Futuristic Career Guidance Goals
Juliet V. Miller, Garry R. Walz, and Libby Benjamin

27. Imaging Futuristic Career Guidance Programs
Juliet V. Miller, Garry R. Walz, and Libby Benjamin

28. Using Change Agent Skills to Manage Career Guidance Program Development
Juliet V. Miller

29. Using Change Agent Skills to Manage Career Guidance Program Implementation
Juliet V. Miller

30. Developing Effective Public Relations
Norman C. Gysbers

31. Developing and Conducting In-Service Programs
Al Stiller

32. Providing Leisure Information in the Career Resource Center
Ron Klein and Robert Swan

33. Developing Career Center Resources for Faculty Use
Marlene Fredricksen and Robert Swan

34. Providing Career Guidance in a Group Setting
Perry Samuels

35. Personalizing Career Guidance Assessment Information Through Group Counseling
Joe Wittmer and Larry C. Loesch

36. Clarifying and Articulating Individual Values and Skills for Career Planning
Jerald R. Forster

37. Helping Parents to Help Adolescents in Career Exploration
Janice M. Birk

38. Helping Young Adults Make the School-to-Work Transition
Sherri Johnson, C. D. Johnson, and Niel Carey

39. Helping the Community Help Students with Career Development
Richard Lutz and Jim Crook

40. Establishing Community-Based Employment Programs
Ellen A. Stewart

41. Designing Career Development Programs for Business and Industry
Zandy Leibowitz and Nancy Schlossberg

42. Developing Coping Skills for Career-Related Changes
Phil Abrego and Lawrence Brammer

43. Helping People with Preretirement Planning--An Introduction
Garry R. Walz, Libby Benjamin, Helen L. Mamarchev, and Beverly Pritchett

44. Counseling Needs of the Older Adult
Patricia Cook and Ellen Stewart

45. Specializing Career Guidance Strategies for Use with Ethnic Minorities
Woodrow M. Parker and Roderick J. McDavis

46. Using Self Awareness and Effective Communication for Helping Ethnic Minorities with Career Guidance
Roderick J. McDavis and Woodrow M. Parker

47. Helping Elementary School Students Develop Decision-Making Skills
Lee Winocur

48. Consulting in the Area of Career Guidance
Tom Quinn

49. Planning Collaborative Career Guidance Projects
Larry C. Loesch and Joe Wittmer

50. Becoming Resource Resourceful
Garry R. Walz, Libby Benjamin, Helen L. Mamarchev, and Beverly Pritchett

51. Making Change Happen: Learning a Systematic Model for Change
Libby Benjamin and Garry R. Walz

52. Making Change Happen: Overcoming Barriers to Change
Libby Benjamin and Garry R. Walz

The National Consortium has also produced a catalog of competency-based programs and lists of desirable competencies for providing comprehensive career guidance.

53 Competency-Based Education for Guidance and Counseling Personnel: A Catalog of Programs and Competencies--Second Edition
Susan L. McBain, Compiler